

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 37 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flintstone	
3. NAME OF DECEASED (Type or print) First Mattie Middle E. Last Ash		4. DATE OF DEATH Month Oct. Day 22 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May. 5-1874
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Chaneyville, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Adams		14. MOTHER'S MAIDEN NAME Barbara Beck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Sacred Heart Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Chronic myocarditis also had Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 924.0 DUE TO Arteriosclerosis with hypertention PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture, neck of right femur.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 7:30 p.m. Sept 5 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard at home.	20f. (City or town) (County) (State) Flintstone Allegany Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 22-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/24/1956	22c. NAME OF CEMETERY OR CREMATORY Flintstone I OOF Cemetery	22d. LOCATION (City, town, or county) (State) Flintstone, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR Oct. 26, 1956	
		24b. REGISTRAR'S SIGNATURE W.L. Frank, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. This certificate is valid for burial, cremation, or removal.

MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 29 1956

RECEIVED

DR. SIMONS

9836 CERTIFICATE OF DEATH

Reg. Dist. No. 4

09819

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 29 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT			
				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RILEY Middle EX F. Last BEAVER				4. DATE OF DEATH Month OCTOBER Day 13 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCTOBER 18, 1890		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired coal miner				10b. KIND OF BUSINESS OR INDUSTRY Coal mining		11. BIRTHPLACE (State or foreign country) BURNSVILLE, N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES BEAVER				14. MOTHER'S MAIDEN NAME TRESA HENSLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 months							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Westernport, Md.		(County) (State)	
21. I certify that I attended the deceased from 9/1/56 , 1956, to 10/1/56 , 1956, that I last saw the deceased alive on 10/1/56 , 1956, and that death occurred at 12:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12 E Union St. Cumberland, Md. DATE SIGNED 10/13/56							
ACTUAL SIGNATURE DR. GEORGE SIMONS				PHYSICIAN'S NAME (Type) DR. GEORGE SIMONS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-56		22c. NAME OF CEMETERY OR CREMATORY Nethkin Hill Cemetery		22d. LOCATION (City, town, or county) (State) Elk Garden, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE E.S. Boal				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR Oct 15, 1956	
				24b. REGISTRAR'S SIGNATURE W. R. Trantz, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 9832 - CERTIFICATE OF DEATH

DATE OF DEATH

ALLEGEDLY

DECEASED

CAUSE

PLACE OF DEATH

DATE OF BIRTH

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AGE

EDUCATION

WHITE

DATE

DECEASED

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BUREAU V. 2

OCT 17 1953

RECEIVED

9837

CERTIFICATE OF DEATH

Reg. Dist. No.

09820

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md				c. LENGTH OF STAY IN 1b 60 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 Race, St.				d. STREET ADDRESS 209 Race St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Amanda Middle Augusta Last Bishop				4. DATE OF DEATH Month October Day 24 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 23, 1886		9. AGE (In years last birthday) yrs. 70	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin V. Smith				14. MOTHER'S MAIDEN NAME Mary Cessna			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Agnes Shoemaker Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO 422.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Ten years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 24, 1956 to October 24, 1956 , that I last saw the deceased alive on October 24, 1956 , and that death occurred at 10:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.				ADDRESS (Street, city or town, state) 202 Virginia Ave		DATE SIGNED 10-25-56	
PHYSICIAN'S NAME (Type) E.E. Broadrup M.D.				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/28/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Washington County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Oct 27, 1956	
				24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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4. 本報為維護讀者利益，特設「讀者信箱」，歡迎讀者來信諮詢、投訴、建議等。信箱地址：本報編輯部。信箱電話：02-23123456。信箱傳真：02-23123457。信箱郵政信箱：100001。

BUREAU V. S.

OCT 30 1956

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in block, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9894

CERTIFICATE OF DEATH

09821

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
c. LENGTH OF STAY IN 1b 10 days		d. STREET ADDRESS R. D. No 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julia Middle C. Last Blubaugh		4. DATE OF DEATH Month 10 Day 9 Year 1956	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-29-1896
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 6 Days 1 Hours 15 Min. 00	IF UNDER 24 HRS. Hours 15 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Grahamtown
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George Saggie	
14. MOTHER'S MAIDEN NAME Susan J. Foutz		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Frank Blubaugh, R. D. No 1 Frostburg	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lower Nebraxon Nebraxosis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Acute Constrictive Heart Failure DUE TO Anterioscaptoic Heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None Hypertensive		INTERVAL BETWEEN ONSET AND DEATH Md. 1 1/2 wks years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 5:30 P		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 7, 1956 to Oct 9, 1956 , that I last saw the deceased alive on Oct 9, 1956 , and that death occurred at 5:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Brown M.D.		ADDRESS (Street, city or town, state) 134 E Main Frostburg, Md.	
PHYSICIAN'S NAME (Type) John C. Brown		DATE SIGNED Oct 11, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-12-56	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home Md.		24a. REC'D BY REGISTRAR 23 E. Main, Frostburg	24b. REGISTRAR'S SIGNATURE DATE 10-12-56

CERTIFICATE OF DEATH

BUREAU V. 3

OCT 15 1956

RECEIVED

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COPY FOR
COUNTY
HEALTH
OFFICE

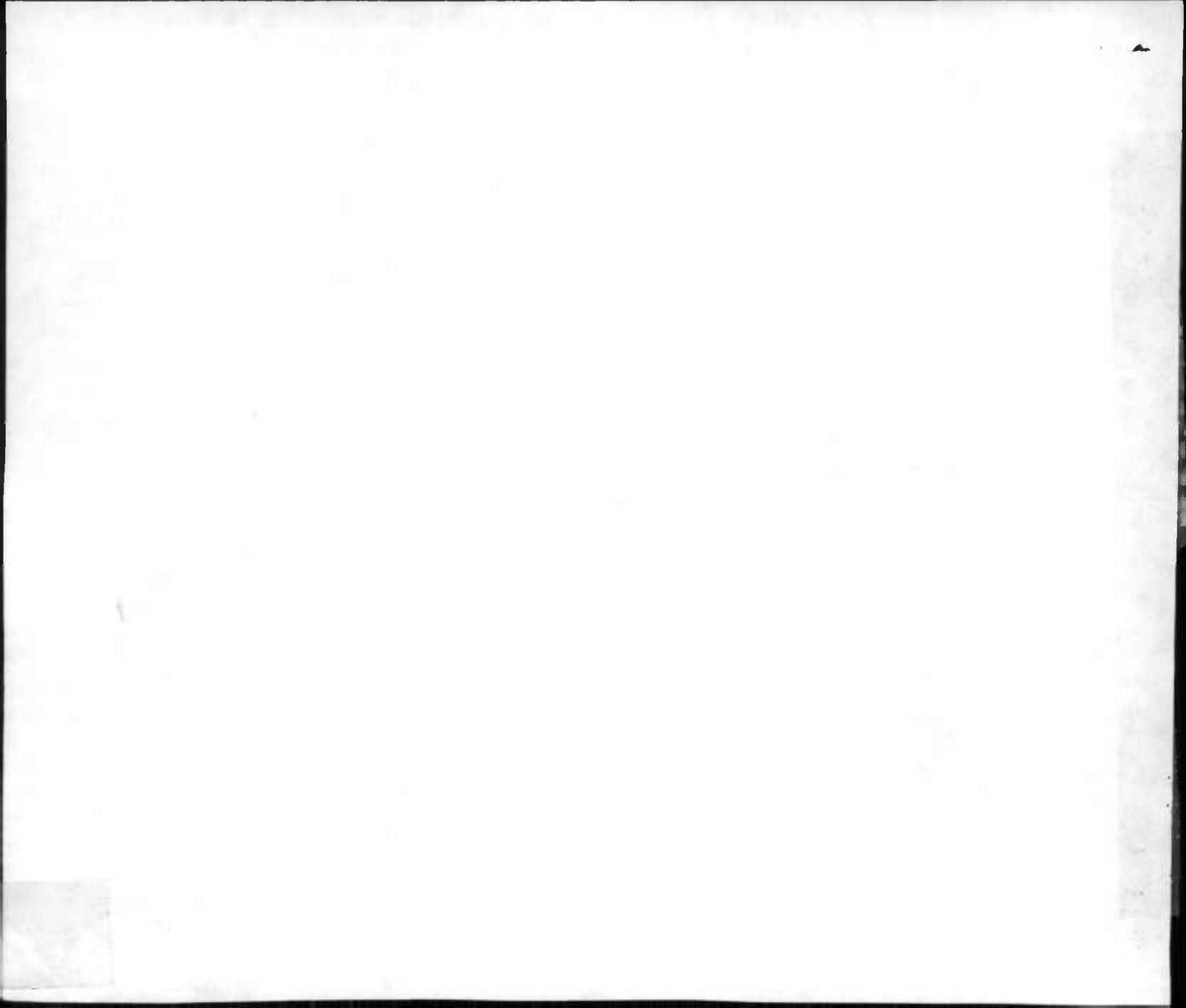
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

NOTE: THIS IS NOT A
LEGAL DOCUMENT

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <u>Allerany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		d. STREET ADDRESS <u>59 Ormond St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>59 Ormond St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Theodore</u> First <u>Francis</u> Middle <u>Bolt</u> Last		4. DATE OF DEATH Month <u>Oct.</u> Day <u>4</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26-1913</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life—even if retired) <u>Spinner-Cellanese Corp. of Am.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eckhart, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Bolt</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Groter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-10-4307</u>	
17. INFORMANT <u>(wife) Frostburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO _____ cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Demina M.D.</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Demina M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct. 4-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-6-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home</u> <u>201 N. Main St. Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u>10-6-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mr. RAUNY H. RAE</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09822

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN lb 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital				d. STREET ADDRESS 96 Braddock St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Mariah Middle Broadwater Last Broadwater				4. DATE OF DEATH Month Oct. Day 7 Year 19 56				
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27-1864		
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Franksville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Stark				14. MOTHER'S MAIDEN NAME Catherine Custer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Miners Hospital records.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (b) ? (a), stating the underlying cause last. DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH several yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 902.0 Fracture of right femur, surgical neck.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Went to get up & off of couch, fell to the floor.					
20c. TIME OF INJURY Month, Day, Year 9 - 9-26 1956		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Frostburg, Allegany, Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE H.V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 7-1956				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 9-1956		22c. NAME OF CEMETERY OR CREMATORY Salisbury Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury Pa		
23. FUNERAL DIRECTOR'S SIGNATURE Stanley M. Thomas <i>Stanley M. Thomas</i>				ADDRESS Salisbury, Pa.		24a. REC'D BY REGISTRAR DATE 10-9-56		
				24b. REGISTRAR'S SIGNATURE <i>Wm. Nancy H. Roe</i>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

OCT 15 1956

RECEIVED

Within corporate limits

DR. FAW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09823

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 30 RACE STREET			
3. NAME OF DECEASED (Type or print) MARY				4. DATE OF DEATH Month OCTOBER Day 22 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-1892		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY U.S.A.							
13. FATHER'S NAME WILLIAM NELSON				14. MOTHER'S MAIDEN NAME MARGARET KELLY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL-MEMORIAL AVENUE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma urinary bladder 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary anemia and cachexia DUE TO (c) secondary to Carcinoma							INTERVAL BETWEEN ONSET AND DEATH 1 year 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sep 1 , 19 56 , to Oct 22 , 19 56 , that I last saw the deceased alive on Oct 22 , 19 56 , and that death occurred at 3:29A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. Fawcett				ADDRESS (Street, city or town, state) Cumberland Md			
DATE SIGNED Oct 22, 1956							
PHYSICIAN'S NAME (Type) DR. FAW							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/25/56		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Oct 26, 1956	
				24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 29 1936

RECEIVED

U. S. DEPT. OF JUSTICE
RECEIVED
OCT 29 1936
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. WHITWORTH

9839

CERTIFICATE OF DEATH

Reg. Dist. No.

09824

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 66 DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				d. STREET ADDRESS 301 WALLACE ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frances Middle Ernestine Last BROWN				4. DATE OF DEATH Month OCTOBER Day 4 Year 19 56			
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 20, 1903	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 5 Days 19 Hours 56		IF UNDER 24 HRS. Months 5 Days 19 Hours 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME THADDEUS KENT				14. MOTHER'S MAIDEN NAME SUZANNE CLIFFORD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia Primary 585 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) malnutrition (long standing) DUE TO (c) Chr. Cholecystitis & Hydrops							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystitis (Hydrops 9.8) -							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July , 19 56 , to Oct , 19 56 , that I last saw the deceased alive on 4 Oct , 19 56 , and that death occurred at 9:35 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Fuller B Whitworth M.D.				ADDRESS (Street, city or town, state) Cumberland Md			
PHYSICIAN'S NAME (Type) Fuller B Whitworth				DATE SIGNED 6 Oct 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-7-1956		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) CUMBERLAND MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumberland Maryland				24a. REC'D BY REGISTRAR DATE Oct 6, 1956		24b. REGISTRAR'S SIGNATURE R. R. Thontz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

OCT 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Within corporate limits
9840
CERTIFICATE OF DEATH

Reg. Dist. No. **09825**

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ACCIDENT 11X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle I Last BURKHARD				4. DATE OF DEATH Month OCTOBER Day 12 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 1, 1909		9. AGE (In years lost birthday) 46 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAFETERIA WORKER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CLARENCE FIKE				14. MOTHER'S MAIDEN NAME LAURA HUMBERSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Elmer Burkhard, Accident Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Abdominal Tumor							INTERVAL BETWEEN ONSET AND DEATH 15 min 3 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 Oct , 19 56 , to 12 Oct , 19 56 , that I last saw the deceased alive on 11 Oct , 19 56 , and that death occurred at 8:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. Stegmaier M.D.				ADDRESS (Street, city or town, state) 122 So. Centre St, Cumberland, Md.			
PHYSICIAN'S NAME (Type) J. G. STEGMAIER				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 16, 56		22c. NAME OF CEMETERY OR CREMATORY Humberston		22d. LOCATION (City, town, or county) (State) Frederickville Garrett Co, Md	
23. FUNERAL DIRECTOR'S SIGNATURE On Newman Grantsville Md				ADDRESS		24a. REC'D BY REGISTRAR W. R. Mertz, M.D.	
				DATE Oct. 16, 1956		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JULY 1956		BALTIMORE		NATURAL	
AGE		SEX		RACE	
65		M		WHITE	
BIRTH DATE		BIRTH PLACE		EDUCATION	
JAN 19 1891		BALTIMORE		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH		IMMEDIATE CAUSE	
RETIRED		HEART DISEASE		CORONARY ARTERY DISEASE	
PREVIOUS ILLNESS		SIGNS AND SYMPTOMS		POST MORTEM	
NONE		PAIN IN CHEST		NONE	
TREATMENT		DATE OF BURIAL		PLACE OF BURIAL	
NONE		JULY 20 1956		BALTIMORE	
SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES	
[Signature]		[Signature]		[Signatures]	
OFFICIAL SEAL		FILING STAMP		RECORDING STAMP	
[Seal]		JUL 21 1956		JUL 21 1956	

BUREAU V. B.

JUL 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits **9841** **CERTIFICATE OF DEATH**

Reg. Dist. No. **9826**

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALLEGANY c. LENGTH OF STAY IN 1b Cumberland, Md. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. at Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RAWLINGS d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PAUL Middle _____ Last CAMPBELL		4. DATE OF DEATH Month October Day 14 , Year 1956					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1913	9. AGE (In years lost birthday) 43 yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Sewage treatment		11. BIRTHPLACE (State or foreign country) Deer Park, Md.			
13. FATHER'S NAME Benjamin Campbell			14. MOTHER'S MAIDEN NAME Alberta Phillips				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 220-10-4547		17. INFORMANT Address Mrs. Mary Alice Campbell, Rawlings, Md.			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____					INTERVAL BETWEEN ONSET AND DEATH 1 hr.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____	(County) _____	(State) _____		
21. I certify that I attended the deceased from 9/21/56 , 19 56 , to 10/14/56 , 19 56 , that I last saw the deceased alive on 10/14/56 , 19 56 , and that death occurred at 5 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 10/19/56							
ACTUAL SIGNATURE Richard J. Williams			PHYSICIAN'S NAME (Type) Richard J. Williams, M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-18-56		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery			
23. FUNERAL DIRECTOR'S SIGNATURE Bolden Funeral Home,		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE Oct. 18, 1956			
24b. REGISTRAR'S SIGNATURE W. R. Trantz, M.D.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

94-1

BUREAU V. 2

OCT 24 1956

RECEIVED

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the general director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9842

CERTIFICATE OF DEATH

Reg. Dist. No.

09827

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 9 DAYS			
d. NAME OF HOSPITAL (If in hospital, give name and address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES				d. STREET ADDRESS STAR ROUTE			
3. NAME OF DECEASED (Type or print) First DOMENICO Middle J. Last JR. CIMAROSA				4. DATE OF DEATH Month OCTOBER Day 29 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 6, 1930		9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator of Roadside Taverns				10b. KIND OF BUSINESS OR INDUSTRY Sicily		11. BIRTHPLACE (State or foreign country) Sicily	
13. FATHER'S NAME DOMENICO J. CIMAROSA SR.				14. MOTHER'S MAIDEN NAME MARIA SERGI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Memorial Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Insufficiency DUE TO (c) Chronic diffuse glomerulo-nephritis						INTERVAL BETWEEN ONSET AND DEATH about 3 months about 3 month ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Fibrosis and Pulmonary edema						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 17, 19 56 , to October 29, 19 56 , that I last saw the deceased alive on October 29, 19 56 , and that death occurred at 1:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Samuel Jacobson</i>				ADDRESS (Street, city or town, state) 50 Pershing Street, Cumberland, Md.			
PHYSICIAN'S NAME (Type) Samuel Jacobson, M.D.				DATE SIGNED 10-30-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Nov. 1, 1956		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery, Oakland, Md.		22d. LOCATION (City, town, or county) (State) Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert C. Reighton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR W.R. Frantz, M.D.		24b. REGISTRAR'S SIGNATURE	

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
JOHN J. WHITE		45		M		W		OCTOBER 20 1956		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND	
HUSBAND OF		MRS. J. WHITE															
BORN		JULY 15 1911															
OCCUPATION		ENGINEER															
CAUSE OF DEATH		HEART DISEASE															
MANNER OF DEATH		NATURAL															
SIGNATURE OF PHYSICIAN		J. J. WHITE															
SIGNATURE OF WITNESSES		J. J. WHITE															
SIGNATURE OF REGISTRAR		J. J. WHITE															

RECEIVED
NOV 1 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained at the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the general director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09828

DR. RANSOM

9843

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY d. STREET ADDRESS RT. #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last COMBS		4. DATE OF DEATH Month OCTOBER Day 20 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 18, 1956
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 2 Hours 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLELAND R. COMBS		14. MOTHER'S MAIDEN NAME BESSIE LLOYD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malposition DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 27 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:37 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 63 Greene St. DATE SIGNED ACTUAL SIGNATURE Leland Ransom M.D. PHYSICIAN'S NAME (Type) DR. LELAND RANSOM Cumberland, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/56	
22c. NAME OF CEMETERY OR CREMATORY Baldwin Cemetery		22d. LOCATION (City, town, or county) (State) Moorefield, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Oct 22 1956 24b. REGISTRAR'S SIGNATURE H. R. Thant, M.D.	

2060388xv4

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.
CERTIFICATE OF DEATH

NAME		LAST		FIRST		MIDDLE	
WHITE		JOHN		DAVID		JAMES	
SEX		MALE		AGE		35	
DATE OF BIRTH		OCTOBER 10, 1922		PLACE OF BIRTH		GREENLAND, VIRGINIA	
OCCUPATION		FARMER		EDUCATION		HIGH SCHOOL	
CAUSE OF DEATH		HEART DISEASE		MANNER OF DEATH		NATURAL	
DATE OF DEATH		OCTOBER 15, 1956		PLACE OF DEATH		GREENLAND, VIRGINIA	
HOSPITAL		GREENLAND HOSPITAL		PHYSICIAN		DR. JAMES W. SMITH	
SIGNATURE OF PHYSICIAN		DR. JAMES W. SMITH		SIGNATURE OF WITNESSES		DR. JAMES W. SMITH	
SIGNATURE OF DEATH REGISTRAR		DR. JAMES W. SMITH		SIGNATURE OF CORONER		DR. JAMES W. SMITH	

BUREAU V. S.

OCT 24 1956

RECEIVED

Within corporate limits MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 224.1/2 N. Lee St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarabelle Middle Couter Last		4. DATE OF DEATH Month Oct. Day 7 Year 1956	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 24-1899
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-Checker-Crystal		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Lee Couter		14. MOTHER'S MAIDEN NAME Lucy Ann Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-16-6822	
17. INFORMANT (sister) Lillian Reinhart, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage (apoplexy)* DUE TO Cerebral vascular sclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331X (c)		INTERVAL BETWEEN ONSET AND DEATH sudden several years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 8-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-56	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Oct. 10, 1956		24b. REGISTRAR'S SIGNATURE M. K. Thant M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATEMENT OF HEALTH - DEATH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU A. B.

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9896

CERTIFICATE OF DEATH

Reg. Dist. No. 6

98820

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 48 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 26 Howard St.				d. STREET ADDRESS 26 Howard St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Russell First Foster Middle DeVore Last				4. DATE OF DEATH Oct. Month 10 Day 19 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1905	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William O. DeVore				14. MOTHER'S MAIDEN NAME Ida Hoyle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 215-20-455		17. INFORMANT Mrs. Pearl DeVore		Address Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolus 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Myocarditis and Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH Six Hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 10, 1956 to October 10, 1956 , that I last saw the deceased alive on October 10, 1956 , and that death occurred at 8:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul B. Wilson				ADDRESS (Street, city or town, state) Piedmont, W. Va.		DATE SIGNED Oct. 11, 1956	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Philos Cem.		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E S Bond				ADDRESS 111 Church St. Westernport, Md.		24a. REC'D BY REGISTRAR DATE 10-13-56	
				24b. REGISTRAR'S SIGNATURE Jean C. Kelly			

STATE OF NEW YORK CERTIFICATE OF DEATH

BUREAU T. A.

OCT 15 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the medical examiner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the medical examiner. Page 5 may be retained by the funeral director. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09831

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Frostburg Cumberland		c. LENGTH OF STAY IN 1b 1.1/2 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS Route 1	
3. NAME OF DECEASED (Type or print) Walter L. Dixon		4. DATE OF DEATH Oct. 7 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 1 1917
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man		10b. KIND OF BUSINESS OR INDUSTRY C.W. Grant Co.	
11. BIRTHPLACE (State or foreign country) Accident, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Dixon		14. MOTHER'S MAIDEN NAME Maude Riley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.2 214-16-2031	
17. INFORMANT Memorial Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis (angina syndrome) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden about 2 weeks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		DATE SIGNED Oct. 7-1956	
EXAMINER'S NAME (Type) H.V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-9-56	
22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cemetery		22d. LOCATION (City, town, or county) (State) Friendsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst		ADDRESS Frostburg, Md.	
24a. REG'D BY REGISTRAR Oct 8, 1956		24b. REGISTRAR'S SIGNATURE W. R. Trant M.D.	

STATE DEPARTMENT OF HEALTH - BATHING 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

OCT 10 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. The funeral director should be given a copy of this certificate. The funeral director should be given a copy of this certificate. The funeral director should be given a copy of this certificate.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 09832											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN TB 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital					d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print) First Katherine Middle Dorsey Last Dorsey					4. DATE OF DEATH Month Oct. Day 12 Year 19 56						
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21-1867		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 89 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Michael Dorsey					14. MOTHER'S MAIDEN NAME Margaret Collins						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Sacred Heart Hospital records.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 490x DUE TO Cardiac hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 902.0 DUE TO (b) ? (c) ?										INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of the inferior ramus of the right pubic bone										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Went to get out of bed and fell to the floor.									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11 -- 29-23 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat' white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Barton Allegany Md.					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE H.V. Deming M.D.					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER Oct. 12-1956											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 10-15-56		22c. NAME OF CEMETERY OR CREMATORY Belvedere Cemetery			22d. LOCATION (City, town, or county) (State) Midland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE E. S. Boal					ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR Oct 15, 1956		24b. REGISTRAR'S SIGNATURE W. F. Thant, M.D.		

MEDICAL CERTIFICATION

about

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]	
Occupation		Education		Marital Status		Date of Death		Place of Death		Time of Death		Physician's Name		Signature of Physician	
[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]	
Signature of Medical Examiner		Name of Medical Examiner		Title of Medical Examiner		Date of Examination		Place of Examination		Time of Examination		Signature of Coroner		Name of Coroner	
[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]		[Illegible]	

BUREAU V. 3

OCT 17 1956

RECEIVED

9847

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY MARYLAND ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 HR. 40 MIN.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS RT.#6 BOWLING GREEN			
3. NAME OF DECEASED (Type or print) WILLIAM D. DRUMM				4. DATE OF DEATH Month OCTOBER Day 25 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4 1889		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Train Disp.				10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN J. DRUMM				14. MOTHER'S MAIDEN NAME PRISCILLA KNIPPENBURG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 705-09-8708		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10.12, 1956 to 10.25, 1956 , that I last saw the deceased alive on 10.25, 1956 , and that death occurred at 9:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 10-26-56			
PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/29/56		22c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 10-29-1956	
				24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove the can papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

OCT 30 1956

RECEIVED

Cambridge, Mass.

10/23/56

ES Post & Paul Can

IN NAME OF DEPARTMENT OF HEALTH

10/23/56

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)	
Allegany		Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cumberland		Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Algonquin Hotel		Algonquin Hotel	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last William Foster Gornall		Month Day Year Oct. 28 19 56	
5. SEX		6. COLOR OR RACE	
male		white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Jan. 27-1880	
9. AGE (In years last birthday)		IF UNDER 1 YEAR	
76 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
ed-machinest- U.S. Navy Yard, Wash. D.C.		Piedmont, W. Va.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
U.S.A.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John F. Gornall		Mary Martha Beall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
no		(son) John M. Gornall, Cumberland, Md.	
17. INFORMANT		Address	
(son) John M. Gornall, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion		sudden	
4201 DUE TO (b) Coronary sclerosis		?	
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) Arteriosclerosis		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 29-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Oct. 31, 1956	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Taylorsville Cemetery		Taylorsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Charles L. George, Cumberland, Maryland.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
		Oct. 30, 1956 W. L. Frank M. D.	

BUREAU V. 2

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09835

Reg. Dist. No.

9849

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 18 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at the Sacred Heart Hospital				d. STREET ADDRESS 12 W. Second St.			
3. NAME OF DECEASED (Type or print) First Hollie Middle Elizabeth Last Goss				4. DATE OF DEATH Month Oct. Day 23 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 8-1893	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 63		IF UNDER 24 HRS. Hours 63 Min. 63			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Oakland, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Lipscomb				14. MOTHER'S MAIDEN NAME Sarah Sines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no				16. SOCIAL SECURITY NO. none			
17. INFORMANT (daughter) Mrs. Ed. Chaney, Cumberland, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 443X DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Arteriosclerosis with hypertention. </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH sudden about 2 years. ?</p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 23-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 26, 1956		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.				24a. REC'D BY REGISTRAR Oct. 24, 1956			
				24b. REGISTRAR'S SIGNATURE W. K.antz, M.D.			

Within corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Report		Time of Report		Place of Report	
Signature of Physician		Signature of Nurse		Signature of Hospital	
Signature of Family		Signature of Friends		Signature of Community	
Signature of Church		Signature of School		Signature of Government	
Signature of Other		Signature of Other		Signature of Other	

BUREAU V. S.

OCT 20 1900
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09836

9897

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francis Middle J. Last Gray		4. DATE OF DEATH Month October Day 17 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 14, 1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. BIRTHPLACE (State or foreign country) Moscow, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Gray	
14. MOTHER'S MAIDEN NAME Agnes Douglas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 214-01-3578		17. INFORMANT Address Mrs. Jane Dunn Midland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung - 163X DUE TO metastasis of above - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 56 , to Oct 17 , 19 56 , that I last saw the deceased alive on October 17, 1956 , and that death occurred at 11:38 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2 Broadway DATE SIGNED 10/19/56 ACTUAL SIGNATURE John B. Davis, M.D. PHYSICIAN'S NAME (Type) John B. Davis, M.D. Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/56	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G EORGE EICHORN		ADDRESS LONACONING, MD.	
24a. REC'D BY REGISTRAR DATE 10-20-56		24b. REGISTRAR'S SIGNATURE Mrs. Nancy V. Poe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09837

Within corporate limits

9850

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) XXXXX Velma Rose GREISE				4. DATE OF DEATH Month OCTOBER Day 8 Year 19 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/28/95		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ROBERT ADAMS				14. MOTHER'S MAIDEN NAME CORA LONG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT PATIENTS CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Hepatitis DUE TO (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-8-1956 to 10-8-1956 , that I last saw the deceased alive on 10-8-1956 , and that death occurred at 10:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. T. Johnson, Jr. M.D.				ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 10-9-56			
PHYSICIAN'S NAME (Type) J. T. Johnson, Jr. M.D.				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/56		22c. NAME OF CEMETERY OR CREMATORY St. Peters & Pauls		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Silcox ; H. Lee				ADDRESS Cumberland, Md.		24a. REG'D BY REGISTRAR DATE Oct 10, 1956 24b. REGISTRAR'S SIGNATURE W. R. Thayer, M.D.	

CERTIFICATE OF DEATH

x

XXXXX Volume 1000

at home

None

BUREAU A. 1

OCT 15 1956

RECEIVED

Cambridge, MA.

H. Lee

10/11/56

St. Paul's & Family

Cambridge, MA.

CERTIFICATE OF DEATH

Reg. Dist. No.

4

9851

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>10 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>112 Bedford St.</u>				d. STREET ADDRESS <u>220 Virginia Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Brenda</u> Middle <u>Rae</u> Last <u>Grimes</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23, 1955</u>	9. AGE (In years last birthday) yrs. <u>10</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>22</u> Hours <u>58</u>		IF UNDER 24 HRS. Months <u>10</u> Days <u>22</u> Hours <u>58</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Grimes</u>				14. MOTHER'S MAIDEN NAME <u>Peggy Jane Yutzey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. George Grimes, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>7544</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital malformation of heart</u> probably transposition of great vessels (c) <u>probably transposition of great vessels</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>9 mo 30 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May 23</u> , 19 <u>56</u> , to <u>Oct. 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 22</u> , 19 <u>56</u> , and that death occurred at <u>255 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph A. Reiter</u>				ADDRESS (Street, city or town, state) <u>112 Bedford St. Cumberland, Md.</u>			
DATE SIGNED <u>Oct. 24, 1956</u>							
PHYSICIAN'S NAME (Type) <u>Ralph A. Reiter, M.D.</u>				112 Bedford St. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-24-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Scarpelli - Cumberland</u>				ADDRESS <u>2260264383</u>		24. REC'D BY REGISTRAR <u>Oct. 24, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz, M.D.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers.

BUREAU V. S.

OCT 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the general director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 of the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9852									
DR. XXXXXX BRINSFIELD									
CERTIFICATE OF DEATH									
Reg. Dist. No. 4									
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE PENNSYLVANIA b. COUNTY Somerset				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 31 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ADDISON				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) ELWOOD			First I Middle HANDWERK Last		4. DATE OF DEATH OCTOBER 29		Month 19 Day 56 Year		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 18, 1916		9. AGE (In years last birthday) 40 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tenant					10b. KIND OF BUSINESS OR INDUSTRY Farmer			11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME LLOYD HANDWERK					14. MOTHER'S MAIDEN NAME BLANCHE RINGLER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 185-26-3210		17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured jejunal ulcer with perforation 542.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recurrent ruptured ulcers (5); two previous DUE TO (c) gastrovascular. Hemiplegia								INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 55 , to Oct 29 , 19 56 , that I last saw the deceased alive on Oct 29 , 19 56 , and that death occurred at 6:03 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 232 Baltimore Ave DATE SIGNED ACTUAL SIGNATURE Carlton Brinsfield M.D. Cumberland Md PHYSICIAN'S NAME (Type) CARLTON BRINSFIELD									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/56		22c. NAME OF CEMETERY OR CREMATORY Zion Lutheran Cemetery			22d. LOCATION (City, town, or county) (State) Addison, Penna.		
23. FUNERAL DIRECTOR'S SIGNATURE Harry Ruchelberger				ADDRESS Addison, Pa.		24a. REC'D BY REGISTRAR Oct 31, 1956		24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.	

U.S. DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
ALBERTA		MALE		21		OCTOBER 2, 1912		PENNSYLVANIA		PHILADELPHIA		PENNSYLVANIA		UNITED STATES	
RACE		COLOR		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		STATE	
WHITE		WHITE		LABORER		HEART DISEASE		NATURAL		HOSPITAL		PHILADELPHIA		PENNSYLVANIA	
FATHER		MOTHER		SPOUSE		CHILD		GRANDCHILD		OTHER		CITY		STATE	
JOHN J. HANSEN		MARY J. HANSEN		JAMES J. HANSEN		JOHN J. HANSEN		MARY J. HANSEN		JOHN J. HANSEN		MARY J. HANSEN		JOHN J. HANSEN	
100-22-2212		100-22-2212		100-22-2212		100-22-2212		100-22-2212		100-22-2212		100-22-2212		100-22-2212	

BUREAU V. 2

NOV 1 1956

RECEIVED

DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
OCTOBER 2, 1912		HOSPITAL		PHILADELPHIA		PENNSYLVANIA		UNITED STATES	
FATHER		MOTHER		SPOUSE		CHILD		GRANDCHILD	
JOHN J. HANSEN		MARY J. HANSEN		JAMES J. HANSEN		JOHN J. HANSEN		MARY J. HANSEN	

Within corporate limits

9853

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 1, Cumberland			
c. LENGTH OF STAY IN 1b 5 Days				d. STREET ADDRESS Route 1 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart-Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Iva Elizabeth Hansel				4. DATE OF DEATH October 1 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1895	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) La Vale, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morton Patterson				14. MOTHER'S MAIDEN NAME Barbara Bigam			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas P. Hansel Address Route 1, Allegany Grove	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diabetic Coma 260X DUE TO (b) Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 25, 1956 to Oct 1, 1956 , that I last saw the deceased alive on Sept 30, 1956 , and that death occurred at 5:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE F. Alan G. Murray M.D.				ADDRESS (Street, city or town, state) Cumberland Md			
DATE SIGNED Oct 2/56							
PHYSICIAN'S NAME (Type) F. Alan G. Murray				M.D. Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/3/56		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer,				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR Walter R. M. M. D.	
DATE Oct 3, 1956							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9523

NAME OF DECEASED [Blank]		SEX [Blank]		AGE [Blank]		DATE OF BIRTH [Blank]	
PLACE OF BIRTH [Blank]		OCCUPATION [Blank]		CAUSE OF DEATH [Blank]		MANNER OF DEATH [Blank]	
DATE OF DEATH [Blank]		TIME OF DEATH [Blank]		PLACE OF DEATH [Blank]		COUNTY [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Blank]		SIGNATURE OF PHYSICIAN [Blank]		SIGNATURE OF CLERK [Blank]	
SIGNATURE OF JUDGE [Blank]		SIGNATURE OF SHERIFF [Blank]		SIGNATURE OF CORONER [Blank]		SIGNATURE OF DEPUTY [Blank]	

BUREAU V. S.

OCT 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09841

9854

1. PLACE OF DEATH o. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN lb 57 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at Sacred Heart Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage d. STREET ADDRESS Foundry Row e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Warren Middle Lee Last Hice		4. DATE OF DEATH Month Oct. Day 21 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26-1899
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57	IF UNDER 24 HRS. Hours 57 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright		10b. KIND OF BUSINESS OR INDUSTRY Kelley-Spg. Tire	
11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Adam Hice		14. MOTHER'S MAIDEN NAME Margaret Jenkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-10-6497	
17. INFORMANT (son) Charles A. Hice		Address Mt. Savage, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock-Intra-abdominal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) fractured pelvis, also fractured 6th. cervical vertebra (c) Compound fracture of left lower leg with large laceration, leg nearly severed. Hit by an auto. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Walking on road near Mt. Savage, Md. & hit by an auto.	
20c. TIME OF INJURY Month, Day, Year Hour 11:50 P. M. Oct. 20 19 56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 36 near Mt. Savage, Allegany Md	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE H. V. Deming M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.		DEPUTY MEDICAL EXAMINER Oct. 21-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/24/56	22c. NAME OF CEMETERY OR CREMATORY St. George Cemetery	22d. LOCATION (City, town, or county) (State) Mt. Savage, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DATE 12/4/1956		24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

MAKING AND STATE DEPARTMENT OF HEALTH - BATHING OR 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

OCT 25 1956

RECEIVED

9898

CERTIFICATE OF DEATH

Reg. Dist. No.

119842

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG MD</u>				c. LENGTH OF STAY IN 1b <u>5 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MINORS HOSP, FROSTBURG, MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG STAR RT</u> 11 X 2			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NANCY</u> Middle <u>HOOPER</u> Last <u>HOOPER</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 1, 1898</u> 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELNAH BITTINGER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA HARE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Melvin Hooper, Frostburg STAR RT.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart dis.; coronary insufficiency</u> <u>260X</u> DUE TO <u>Early acidosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Acute Gastric Dilatation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>± 1 yr</u> <u>2 wks</u> <u>8 yrs</u> <u>2 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>July 6, 1947</u> , to <u>October 1, 1956</u> , that I last saw the deceased alive on <u>Oct. 1, 1956</u> , and that death occurred at <u>9:26 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank T. Harrat</u> M.D.				ADDRESS (Street, city or town, state) <u>26 Mechanic St Frostburg, Md</u>			
PHYSICIAN'S NAME (Type) <u>FRANK T. HARRAT</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Oct 4 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>JOHNSON</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL FROSTBURG MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DONALD F. HURMAN</u> ADDRESS <u>Quantico Rd</u>				24a. REC'D BY REGISTRAR <u>10-9-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy H. Re</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the general director. After this certificate has been signed by the attending physician and completed, it should be filed with the general director. After this certificate has been signed by the attending physician and completed, it should be filed with the general director. After this certificate has been signed by the attending physician and completed, it should be filed with the general director.

CERTIFICATE OF DEATH

ALLEN, Wm

Residing at 1100

Married to

Wm

Female

Age 11

Cause of Death

Heart Failure

BUREAU V. 2

OCT 15 1956

RECEIVED

Received by Baltimore Health Dept. Oct 15 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09843

Reg. Dist. No.

9855

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Corrigansville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS R.F.D.#1 Cumberland, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle E Last Howell				4. DATE OF DEATH Month Oct. Day 28 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4-1908		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Press changer-Big		10b. KIND OF BUSINESS OR INDUSTRY Corp. Savage Refractory		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josephus Howell				14. MOTHER'S MAIDEN NAME Ada Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-1973		17. INFORMANT Address Memorial Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 519.2 IMMEDIATE CAUSE (a) Cardiac failure due to mitral stenosis DUE TO Cardiac hypertrophy (marked) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Hydrothorax also had ascities						INTERVAL BETWEEN ONSET AND DEATH Gradual ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Amount of silica, pending autopsy report.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Oct. 29-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-31-56		22c. NAME OF CEMETERY OR CREMATORY North Glades		22d. LOCATION (City, town, or county) (State) Swanton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leigler				ADDRESS Hyndman Rd		24a. REC'D BY REGISTRAR October 30 1956	
				24b. REGISTRAR'S SIGNATURE W.R. Frank M.D.			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WISCONSIN STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		10-15-1956	
Place of Birth		Occupation		Cause of Death		Manner of Death	
New York City		Teacher		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician's Signature	
10-15-1956		10:30 AM		New York City		J. Doe, M.D.	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Director	
J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	

BUREAU V. 2

NOV 1 1956

RECEIVED

DR. VAN ORMER

9856

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 118 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL- MEMORIAL & WARWICK AVES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) ARTIE E HUFFMAN		4. DATE OF DEATH Month OCTOBER Day 23 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 19 1892
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith helper		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	
11. BIRTHPLACE (State or foreign country) VIRGINIA Port Republic U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES HUFFMAN		14. MOTHER'S MAIDEN NAME Elizabeth Matheney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 208-09-1881	
17. INFORMANT Mrs. Anna Huffman Mt. Savage, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 Oct. 1956 to 23 Oct. 1956 , that I last saw the deceased alive on 23 Oct. 1956 , and that death occurred at 3:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE James G. Stegmaier M.D. 22 So Centre St., Cumberland			
PHYSICIAN'S NAME (Type) Dr. James G. Stegmaier			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/26/56	
22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 27/1956	
		24b. REGISTRAR'S SIGNATURE W.R. Frank M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DR. VAN ORSER, M.D.

ALLSOUTH

W. DAWSON

115 DAYS

CHICAGO

CHICAGO HOSPITAL

CHICAGO HOSPITAL

OCTOBER 23, 1956

W. DAWSON

WHITE

CHICAGO

WHITE

CHICAGO

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CHICAGO

CHICAGO

BUREAU V. B.

OCT 30 1956

RECEIVED

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits										MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09845	
DR. HALLINAN 9857										CERTIFICATE OF DEATH										Reg. Dist. No. 4	
1. PLACE OF DEATH a. COUNTY ALLEGANY					MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					b. COUNTY ALLEGANY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 21 DAYS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL										d. STREET ADDRESS 221 SOUTH STREET					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First JOHN Middle HUNTER Last					4. DATE OF DEATH Month OCTOBER Day 14 Year 19 56																
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 4 1898		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FILLER					10b. KIND OF BUSINESS OR INDUSTRY AIR REDUCTION SALES					11. BIRTHPLACE (State or foreign country) SCOTLAND					12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME DAVID HUNTER					14. MOTHER'S MAIDEN NAME MARY RAMSEY																
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 185 14 9718					17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis-generalized</u> 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic carcinoma, left lung</u> DUE TO (c) <u>cachexia</u>										INTERVAL BETWEEN ONSET AND DEATH 3 mo. 9 mo. 2 mo.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none																
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. none 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from July 9, 19 56, to October 14, 19 56, that I last saw the deceased alive on October 14, 19 56, and that death occurred at 8:35 A.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) 140 Bedford St., Cumberland, Md.										DATE SIGNED 10/14/56	
ACTUAL SIGNATURE DR. JAMES HALLINAN					PHYSICIAN'S NAME (Type) DR. JAMES HALLINAN																
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF 10-17-1956					22c. NAME OF CEMETERY OR CREMATORY I.O.O.F CEMETERY					22d. LOCATION (City, town, or county) (State) ELK GARDEN, W.VA.						
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. KIGHT, CUMBERLAND, MARYLAND					ADDRESS					24a. RECEIVED BY REGISTRAR DATE Oct 16, 1956					24b. REGISTRAR'S SIGNATURE W. R. Dantz, M.D.						

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BUREAU V. 81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

Within corporate limits MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. HIMMELWRIGHT

9858

CERTIFICATE OF DEATH

Reg. Dist. No. 4

09846

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 36 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK AVES.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 31 FIFTH ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELBERT H JONES		4. DATE OF DEATH Month Day Year OCTOBER 8 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-27-06
9. AGE (In years lost birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Textile Industry	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY JONES		14. MOTHER'S MAIDEN NAME MINNIE SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> War II		16. SOCIAL SECURITY NO. 217-10-4488	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia - Bacterial INTERVAL BETWEEN ONSET AND DEATH 4 weeks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 19 55 to Oct , 19 56 , that I last saw the deceased alive on Oct 8 , 19 56 , and that death occurred at 4:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Oct 9, 1956			
ACTUAL SIGNATURE G. Overton Himmelwright M.D.			
PHYSICIAN'S NAME (Type) G. Overton Himmelwright 133 Virginia Ave. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-11-56	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. RECEIVED BY REGISTRAR Oct 11, 1956	
24b. REGISTRAR'S SIGNATURE W. R. Mantz, M.D.			

CERTIFICATE OF DEATH

FILE NO. 100-3-101

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BUREAU V. S.

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

9859

CERTIFICATE OF DEATH

Reg. Dist. No.

09847

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>29 Maple Street</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>29 Maple Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>THEODORE THOMAS KIDWELL</u>				4. DATE OF DEATH Month Day Year <u>October 1 19 56</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 21, 1888</u>							
9. AGE (In years last birthday) <u>68</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tire Builder, Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly-Springfield</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
Hours	Min.										
11. BIRTHPLACE (State or foreign country) <u>Paw Paw, West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George W. Kidwell</u>				14. MOTHER'S MAIDEN NAME <u>Julia Slain</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW 1</u>		16. SOCIAL SECURITY NO. <u>217-10-1068</u>		17. INFORMANT <u>Mrs. Elwood Dean, 29 Maple Street, Cumberland, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> <u>Coronary Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Paroxysm</u> DUE TO (c) <u>Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Descending Colon</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Aug</u> <u>1956</u> to <u>Oct</u> <u>1956</u> that I last saw the deceased olive on <u>Sept 30, 1956</u> and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>133 Va. Ave., Cumberland, Maryland</u> DATE SIGNED <u>10/2/56</u> ACTUAL SIGNATURE <u>G. Overton Himmelwright</u> M.D. PHYSICIAN'S NAME (Type) <u>G. Overton Himmelwright</u> M.D. <u>133 Va. Ave., Cumberland, Maryland</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodrow Union Cemetery</u>							
22d. LOCATION (City, town, or county) (State) <u>Paw Paw, West, Virginia</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, 230 Baltimore Avenue, Cumberland, Maryland</u>									
24a. REC'D BY REGISTRAR <u>Oct 3, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Walter R. Brady MD</u>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. B.

100 5 1956

RECEIVED

9995

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Md.</u>	<u>Allegany</u> COUNTY
CITY (If outside corporate limits, write OR and give nearest town) <u>Kifer</u>	RURAL <input type="checkbox"/> LENGTH OF STAY (in this place) <u>80</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kifer</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>/</u>	
3. NAME OF DECEASED: (First) <u>Naomi</u> (Middle) (Last) <u>Kifer</u>		4. DATE OF DEATH: (Month) <u>Oct.</u> (Day) <u>6</u> (Year) <u>1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>Nov. 5, 1875</u>
9. AGE last birthday: <u>80</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Kifer, Md</u>	
11. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housework</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>David Kifer</u>		14. MOTHER'S MAIDEN NAME: <u>Amanda Ashkettle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mrs Grace Robertson</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
527.2 Immediate cause (a) <u>Ac. Bcep. Tract. Infection</u>		<u>7 mks</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Intra Cranial Hemorrhage</u>		<u>7 1/2 yrs</u>
(c) <u>Arterio sclerosis</u>		<u>10 yrs</u>

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
SUICIDE		(CITY OR TOWN)	
HOMICIDE		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		(STATE)	
INJURY OCCURRED		HOW DID INJURY OCCUR ?	
While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from 10-2-56 to Oct 2nd 1956, that I last saw the deceased alive on 10-2-56, and that death occurred at 7:30 PM from the causes and on the date stated above.

SIGNATURE <u>J. S. Armstrong M.D.</u>		ADDRESS <u>Fairfax Va</u>	
DATE SIGNED <u>10-7-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct. 9, 1956</u>	<u>Rose Hill Cemetery</u>	<u>Hagerstown, Md</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Oct. 8, 1956</u>	<u>Mrs. Jay Duckworth</u>	<u>W W Parker</u>	<u>Keokuk, Iowa</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 11 1956

RECEIVED

9860

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
c. LENGTH OF STAY IN 1b 5/25/55		d. STREET ADDRESS 244 Centre St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) George Henry Kroll		4. DATE OF DEATH Month October Day 27 Year 1956	
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/1888	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Coal Miner - Mining	10b. KIND OF BUSINESS OR INDUSTRY Frostburg, Maryland	11. BIRTHPLACE (State or foreign country) U. S. A.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13. FATHER'S NAME Herman Kroll	14. MOTHER'S MAIDEN NAME Elizabeth Lapp
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 214-01-3747	17. INFORMANT P.O.Box 599, Address Cumberland, Md. Allegany County Infirmary Records
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostosis DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Hemorrhage DUE TO Chronic myocarditis (c) Left Hemiplegia		INTERVAL BETWEEN ONSET AND DEATH 36 hrs ? ?
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 49 Greene St.,
20f. (City or town) Cumberland, Md.		(County) (State)

21. I certify that I attended the deceased from 5/25/55 , 19____, to 10/27/56 , 19____, that I last saw the deceased alive on 10/27/56 , 19____, and that death occurred at 6:45A M, from the causes and on the date stated above.	
ACTUAL SIGNATURE James E. McLean M.D.	DATE SIGNED October 27, 1956
PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-29-1956	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial	22d. LOCATION (City, town, or county) (State) Frostburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Winters		24a. REC'D BY REGISTRAR Oct 30, 1956	24b. REGISTRAR'S SIGNATURE W. B. Trout, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in pages 1 and 2, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

92-50

Name of Deceased		George Henry	
Age		27	
Sex		Male	
Race		White	
Date of Death		10/6/55	
Place of Death		Hospital - Coal Mine - Mining	
Cause of Death		Horseman Knoll	
Manner of Death		Illness	
Occupation		Miner	
Residence		214 Centre St.	
City		Birmingham	
County		Jefferson	
State		Alabama	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	
Signature of Burial Officer		[Signature]	
Signature of Minister		[Signature]	
Signature of Undertaker		[Signature]	
Signature of Witness		[Signature]	
Signature of Deceased		[Signature]	
Signature of Family		[Signature]	
Signature of Friend		[Signature]	
Signature of Neighbor		[Signature]	
Signature of Other		[Signature]	

BUREAU A. 7

NOV 1 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11975

Reg. Dist. No.

9899

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Zihlman</u>	
c. LENGTH OF STAY IN lb <u>45 days</u>		d. STREET ADDRESS <u>R.F.D.#2 Frostburg, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In woods, 1 miles north of Little Tunnel, W. Md. R.R.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George L. Langford</u>		4. DATE OF DEATH Month Day Year <u>About Oct. 24 19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27-1891</u>
9. AGE (In years last birthday) <u>65 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>65 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-Big Savage Refractory Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Zihlman, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Langford</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Stoddard.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-10-6310</u>	
17. INFORMANT Address <u>Md.</u> <u>(daughter) Mrs. Clayton Garlitz, Zihlman</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination due to a shattered skull</u> DUE TO (b) <u>from a 16 guage shot gun.(self inflicted)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>976x</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>Shattered skull, shot himself in woods.</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>about Oct. 24 19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>In woods (near) Frostburg Allegany Md.</u>		20f. (City or town) (County) (State) <u>Frostburg Allegany Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>Dec. 9-1956</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-9-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst,</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>12-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy A. Rose</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. The funeral director should be used as a burial transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU

DEC 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9900
CERTIFICATE OF DEATH

69850
9

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg				c. LENGTH OF STAY IN b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARGARET Middle AGNES Last LANGFORD				4. DATE OF DEATH Month Oct. Day 29 Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-25-1909	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		11. BIRTHPLACE (State or foreign country) New Jersey	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Daube				14. MOTHER'S MAIDEN NAME Kathleen Lenahan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 142-16-5917			
17. INFORMANT Address R.F.D.2, Mrs. Clayton Garlitz, Frostburg, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac dilatation DUE TO 474x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laryngo-Tracheitis, acute DUE TO (c) Asthmatic Bronchitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis INTERVAL BETWEEN ONSET AND DEATH ± 15 min. 5d 12 yrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/26 , 19 56 , to 10/29 , 19 56 , that I last saw the deceased alive on 10/29 , 19 56 , and that death occurred at 2:50 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank T. Harrat M.D.				ADDRESS (Street, city or town, state) 26 Mechanic St. Frostburg, Md.			
DATE SIGNED 10/31/56							
PHYSICIAN'S NAME (Type) FRANK T. HARRAT M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-2-56		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, ADDRESS Frostburg, Md.				24a. REC'D BY REGISTRAR 11-2-56 24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Poe			

CERTIFICATE OF DEATH

NAME OF DECEASED A. J. DAVIS		DATE OF DEATH 1956	
AGE 2 years		SEX Male	
RACE White		EDUCATION None	
BIRTH DATE 1954		BIRTH PLACE Maryland	
MARRIAGE None		OCCUPATION None	
RESIDENCE 1234 Main St., Baltimore, Md.		PLACE OF DEATH Home	
CAUSE OF DEATH Sudden Infant Death Syndrome		MANNER OF DEATH Natural	
DATE OF BURIAL 1956		PLACE OF BURIAL St. Mary's Cemetery, Baltimore, Md.	
SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		SIGNATURE OF REGISTRAR J. H. Smith, M.D.	
DATE OF SIGNATURE 1956		DATE OF SIGNATURE 1956	

BUREAU V. 3

NOV 5 1956

RECEIVED

11

VS. A15ME(5)
SM 9/55

BUREAU V. S.

OCT 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09852

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN lb 2 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 445 Walnut St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clifton Middle Otha Last Liller		4. DATE OF DEATH Month Oct. Day 27 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27-1894
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-Acetate Dept Op.		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	11. BIRTHPLACE (State or foreign country) New Creek, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Liller	
14. MOTHER'S MAIDEN NAME Eliza Blackburn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 220-10-8535		17. INFORMANT (wife) Lola Liller, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac hypertrophy DUE TO Pulmonary edema (c) 3 hrs			INTERVAL BETWEEN ONSET AND DEATH about 3 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 29, 1956	
22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		22d. LOCATION (City, town, or county) (State) Fort Ashby, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.		24a. REC'D BY REGISTRAR Oct. 29, 1956	
24b. REGISTRAR'S SIGNATURE W. K. Francis M.D.		DATE SIGNED	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained in your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

OCT 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO GENERAL REGISTAR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5967

CERTIFICATE OF DEATH

Reg. Dist. No.

09853

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. Corrigansville c. LENGTH OF STAY IN 1b R. D. Corrigansville d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ellerslie Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. Corrigansville d. STREET ADDRESS Ellerslie Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First IDA Middle MAY Last LILLER		4. DATE OF DEATH Month Oct. Day 5, Year 1956					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12, 1872	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 14	IF UNDER 24 HRS. Days hrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Rio, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Harvey Daugherty			14. MOTHER'S MAIDEN NAME Rebecca Wolford				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Richard Workman Corrigansville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 14 hrs.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov-10 , 19 55 , to Oct-5 , 19 56 , that I last saw the deceased alive on Oct. 4 , 19 56 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William P. James		M.D. 441 N. Centre St.					
PHYSICIAN'S NAME (Type) William P. James		Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/56		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR Oct 8, 1956	24b. REGISTRAR'S SIGNATURE M. R. Thant, M.D.

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09854

Within corporate limits MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 5 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Howard Last Maguire		4. DATE OF DEATH Month Oct. Day 12 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27-1900
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. & owner		10b. KIND OF BUSINESS OR INDUSTRY Grand Motel	
11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Getty Maguire		14. MOTHER'S MAIDEN NAME Anna Gordon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 189-12-4475	
17. INFORMANT Address R.F.D. #1		18. (wife) Ruth Brant Maguire, La Vale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis (angina syndrome) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 12-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 15-1956	22c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	22d. LOCATION (City, town, or county) (State) Berlin Pa.
23. FUNERAL DIRECTOR'S SIGNATURE W.A. Johnson		ADDRESS Berlin, Pa.	
24a. REC'D BY REGISTRAR Oct. 15, 1956		24b. REGISTRAR'S SIGNATURE W.R. Brant M.D.	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. The funeral director should be given a copy of this certificate. The funeral director should be given a copy of this certificate. The funeral director should be given a copy of this certificate.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased Robert Henry Karpis		Age 34		Sex Male		Race White	
Date of Death October 17, 1936		Place of Death Federal Penitentiary, J. Edgar Hoover Building, Washington, D.C.		Cause of Death Homicide		Manner of Death Murder	
Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]		Signature of Police Officer [Signature]		Signature of Witness [Signature]	
City Baltimore		County Baltimore		State Maryland		Country United States of America	
Date of Birth [illegible]		Date of Death October 17, 1936		Time of Death [illegible]		Place of Death Federal Penitentiary, J. Edgar Hoover Building, Washington, D.C.	
Name of Deceased Robert Henry Karpis		Age 34		Sex Male		Race White	
Date of Death October 17, 1936		Place of Death Federal Penitentiary, J. Edgar Hoover Building, Washington, D.C.		Cause of Death Homicide		Manner of Death Murder	
Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]		Signature of Police Officer [Signature]		Signature of Witness [Signature]	
City Baltimore		County Baltimore		State Maryland		Country United States of America	
Date of Birth [illegible]		Date of Death October 17, 1936		Time of Death [illegible]		Place of Death Federal Penitentiary, J. Edgar Hoover Building, Washington, D.C.	

RECEIVED
OCT 17 1936
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. File pages 1 and 2 with the registrar for burial or removal. File page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

9855

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 20 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at the Sacred Heart Hospital.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (rural) Cumberland d. STREET ADDRESS R.F.D.#3 Bowmans Addition e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Jacob Mallow		4. DATE OF DEATH Month Oct. Day 2 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18-1907
9. AGE (in years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Turbine operator		10b. KIND OF BUSINESS OR INDUSTRY Potomac Edison	
11. BIRTHPLACE (State or foreign country) Brandywine, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Mallow		14. MOTHER'S MAIDEN NAME Alice Kimble	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-10-5555	
17. INFORMANT (wife) Dela Johnson Mallow, Cumberland, Md.		Address R.F.D.#3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis (angina syndrome) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden 2 hrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Oct. 2-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/56	
22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Oct. 5, 1956		DATE Oct. 5, 1956	
24b. REGISTRAR'S SIGNATURE M. R. Wantz, M.D.		DATE Oct. 5, 1956	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Manner of Death		Place of Death		Date of Death		Time of Death		Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Juror		Signature of Witness		Signature of Other	
John Doe		30 yrs.		Male		White		Caucasian		Roman Catholic		Single		Laborer		Heart Disease		Natural		Home		Oct 10, 1955		10:00 AM		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	

RECEIVED
OCT 10 1955
BUREAU V. 2

ORIGINAL FILED

9864

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE WEST VIRGINIA b. COUNTY Hampshire			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 37 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 85X-3			
3. NAME OF DECEASED (Type or print) First MARY Middle C Last MARTIN				4. DATE OF DEATH Month OCTOBER Day 24 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-1891		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House				10b. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (State or foreign country) SPRINGFIELD, W.VA.	
13. FATHER'S NAME WILLIAM W. SHANNON				14. MOTHER'S MAIDEN NAME EDITH M. SMOUSE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Memorial Hospital Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma left breast 170X DUE TO (b) Metastatic carcinoma left femur DUE TO (c) Pathological fracture left femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 1951 , 19___, to Oct 24 , 19 56 , that I last saw the deceased alive on Oct 24 , 19 56 , and that death occurred at 9:10A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.M. Faw Jr.				DATE SIGNED 5 Washington St. Cumberland Md.			
PHYSICIAN'S NAME (Type) WYLIE M. FAW JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 26 1956		22c. NAME OF CEMETERY OR CREMATORY Hill Cemetery		22d. LOCATION (City, town, or county) (State) Springfield W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph Guthrie ADDRESS Springfield, W. Va.				24a. REC'D BY REGISTRAR Oct 25, 1956		24b. REGISTRAR'S SIGNATURE W.R. Mantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

OCTOBER

1956

EDITH M. SHAW

WILLIAM M. SHAW

BUREAU V. 3

OCT 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

99857

9908

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>55 Years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural.</u> <u>Cumberland</u>		d. STREET ADDRESS <u>Route 3, Bedford Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 3, Bedford Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leslie</u> Middle <u>Ray</u> Last <u>Mauk</u>		4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 23 1896</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School Bus</u>	
11. BIRTHPLACE (State or foreign country) <u>Bedford County, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA;</u>	
13. FATHER'S NAME <u>Espey J. Mauk</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Wigfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-20-5772</u>	
17. INFORMANT <u>Mrs. Helen M. Mauk</u>		Address <u>RFD 3, Cumberland Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Granulocytic leukemia</u> <u>294x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Polyarthralgia</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos -</u> <u>14 yrs -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> to <u>Oct 7</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Oct 5</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>441 N. Pearl St.</u> DATE SIGNED <u>10-8-56</u>			
ACTUAL SIGNATURE <u>William R. James</u> M.D.		PHYSICIAN'S NAME (Type) <u>William R. James</u> <u>Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 10 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Light</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>Oct 9, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>R. R. Thontz, M.D.</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

RECEIVED
OCT 11 1956
BUREAU V. 1

9865

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.VA. b. COUNTY Mineral			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES				d. STREET ADDRESS BURLINGTON			
3. NAME OF DECEASED (Type or print) First LUCY Middle M Last MC DONALD				4. DATE OF DEATH Month OCTOBER Day 31 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 15 1881		9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House			10b. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (State or foreign country) W.VA.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIS VEST XXXXXXXXXXXX				14. MOTHER'S MAIDEN NAME ELIZABETH WHIPP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Memorial Hospital, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arteriosclerosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio vascular disease DUE TO (c) 8 yrs.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-23 , 19 56 to 10-31 , 19 56 , that I last saw the deceased alive on 10-31 , 19 56 , and that death occurred at 1:38 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 10/31/56			
PHYSICIAN'S NAME (Type) W. F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 3, 1956		22c. NAME OF CEMETERY OR CREMATORY Laymansville Cemetery		22d. LOCATION (City, town, or county) (State) Laymansville, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Blaine Schaeffer, Petersburg, W. Va.				24a. REC'D BY REGISTRAR Nov. 4, 1956		24b. REGISTRAR'S SIGNATURE Walter R. Grant, Md.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

NOV 2 1956

RECEIVED

DR. WEISMAN

9866

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 2HR. 15 MINS.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 101 Winchester Road		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LEO		First C Middle MC KENZIE Last		4. DATE OF DEATH Month OCTOBER Day 24 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 13, 1891		9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Machinist			10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) MARYLAND Cresaptown		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE MC KENZIE				14. MOTHER'S MAIDEN NAME MARY HERSHBERGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. 1		16. SOCIAL SECURITY NO. 217-10-4736		17. INFORMANT Address MEMORIAL HOSPITAL-CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Damage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Insufficiency DUE TO (c) Arteriosclerosis Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs 2 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Tachycardia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 55 , to Oct 24 , 19 56 , that I last saw the deceased alive on July , 19 55 , and that death occurred at 4:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md DATE SIGNED 10/24/56							
ACTUAL SIGNATURE S. L. Weisman		M.D. Cumberland, Md					
PHYSICIAN'S NAME (Type) S. L. Weisman, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24. REC'D BY REGISTRAR W. K. Frank, M.D.		24b. REGISTRAR'S SIGNATURE W. K. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the registrar, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2282

NO. 123456

DECEASED: **WILLIAM** **WILLIAM**

DATE OF DEATH: **1956** **10** **10**

PLACE OF DEATH: **GENERAL HOSPITAL - 1000 W. 10th St.**

AGE: **60** **years** **10** **months** **10** **days**

SEX: **Male**

RACE: **White**

EDUCATION: **High School**

OCCUPATION: **Retired**

CAUSE OF DEATH: **Heart Disease**

IMMEDIATE CAUSE: **Myocardial Infarction**

UNDERLYING CAUSE: **Coronary Artery Disease**

DATE OF BIRTH: **1956** **10** **10**

PLACE OF BIRTH: **St. Louis, Missouri**

DATE OF DEATH: **1956** **10** **10**

TIME OF DEATH: **10:00 AM**

DATE OF DEATH: **1956** **10** **10**

TIME OF DEATH: **10:00 AM**

DATE OF DEATH: **1956** **10** **10**

TIME OF DEATH: **10:00 AM**

BUREAU V. S.

OCT 30 1956

RECEIVED

9901

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
c. LENGTH OF STAY IN 1b 18 days		d. STREET ADDRESS 17 Frost Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle McPARTLAND Last McPARTLAND		4. DATE OF DEATH Month 10 Day 17 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Lonaconing		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Higgins		14. MOTHER'S MAIDEN NAME Mary Douglas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary McFarland		Address 17 Frost Ave. Frostburg Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) Gravely ill Secondary to Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 days year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from OCT 10 , 19 56 , to OCT 17 , 19 56 , that I last saw the deceased alive on OCT 10 , 19 56 , and that death occurred at M , from the causes and on the date stated above.	
ACTUAL SIGNATURE John C. Devereaux M.D.	ADDRESS (Street, city or town, state) 134 E Main DATE SIGNED 10/18/56
PHYSICIAN'S NAME (Type) John C. Devereaux Frostburg, Md	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-19-56	22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Buriah H. Montesanti ADDRESS 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 10-19-56	24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Rose

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 23 1956

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09861

9867

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 527 DILLY STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle V. Last MILLER				4. DATE OF DEATH Month OCT. Day 12, Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 1, 1895	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEPUTY REGISTER WILLIS COUNTY				10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MD.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME JOHN H. MILLER				14. MOTHER'S MAIDEN NAME AGNES HARTSOCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS. MARAGARET MILLER, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260.0 (b) generalized arteriosclerosis DUE TO (c) years							INTERVAL BETWEEN ONSET AND DEATH 1/2 hour years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus, duodenal ulcer, angiotrophic lateral sclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 10/12 to 10/14 , 19 56 , that I last saw the deceased alive on 10/12 , 19 56 , and that death occurred at M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Elizabeth Brings		M.D. 55 Greene St.		DATE SIGNED 10/16/56			
PHYSICIAN'S NAME (Type) ELIZABETH BRINGS		Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-17-1956		22c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEMETERY		22d. LOCATION (City, town, or county) (State) FROSTBURG, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. KIGHT, CUMBERLAND, MARYLAND				24a. RECEIVED BY REGISTRAR DATE Oct. 16, 1956		24b. REGISTRAR'S SIGNATURE W. R. Prater, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director must file it with the health department. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. The registrar will then issue a burial or cremation permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 8

RECEIVED

9868

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>D. O. A. at Memorial Hospital</u>				d. STREET ADDRESS <u>118 Winton Place</u>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>JOSEPHINE</u> Last <u>MITCHELL</u>				4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1895</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Examiner Textile Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celeane Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Carlos, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John F. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Whitfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-6435</u>		17. INFORMANT <u>John F. Mitchell, 118 Winton Place, Cumberland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary and Hypertensive Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>10-17-55</u> , 19 _____ to <u>10-31-56</u> , 19 _____, that I last saw the deceased alive on <u>10-31-56</u> , 19 _____, and that death occurred at <u>11:25 pm</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph W. Ballin</u>		ADDRESS (Street, city or town, state) <u>62 Greene St. Cumberland, Md.</u> DATE SIGNED <u>11-1-56</u>					
PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 3, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>S. S. Peter & Pauls Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>Nov. 4, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0238

MARY A STATE DEPARTMENT OF HEALTH - BALTIMORE 18

RECEIVED
NOV 7 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9869

CERTIFICATE OF DEATH

Reg. Dist. No.

09863

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>Cumberland,</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>			d. STREET ADDRESS <u>208 Central Ave.</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Hilda</u> Middle <u>Irene</u> Last <u>Naughton</u>			4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3rd, 1906</u>		9. AGE (In years last birthday) <u>50</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Former Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles Reynolds</u>			14. MOTHER'S MAIDEN NAME <u>Vemma Jolley</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>212-18-1995</u>		
17. INFORMANT <u>Patient's Chart</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Tumors</u> DUE TO <u>237x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 yrs</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>September 5, 1956</u> to <u>October 10, 1956</u> that I last saw the deceased alive on <u>10-10-1956</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>J. T. Johnson, Jr.</u>		M.D. <u>Cumberland, Md.</u>		DATE SIGNED <u>10-12-56</u>	
PHYSICIAN'S NAME (Type) <u>J. T. Johnson, Jr., M.D.</u>		<u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks Cemetery</u>	
22d. LOCATION (City, town, or county)		(State) <u>Cumberland, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>Oct 13, 1956</u>		
24b. REGISTRAR'S SIGNATURE <u>W. R. Mertz, M.D.</u>					

CERTIFICATE OF DEATH

23

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1956

10-10-56

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF DECEASED</p>	
<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>	
<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF DECEASED</p>	
<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>	
<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF DECEASED</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>	
<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>	
<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF DECEASED</p>	
<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>	
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<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>	
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<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>	
<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>	
<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>	
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<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>	
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<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>	
<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF DECEASED</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>	
<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. S.

OCT 17 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 09864									
1. PLACE OF DEATH o. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE W.Va. b. COUNTY Mineral				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at the Memorial Hospital					d. STREET ADDRESS Carpenter's Addition			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Theresa Middle Lee Last Nicholson					4. DATE OF DEATH Month Oct. Day 14 Year 19 56				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10-1956		9. AGE (In years last birthday) 0 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Winchester, Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Nettie Nicholson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Bessie Null, Ridgely, W.Va.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 500X Acute tracheal bronchitis DUE TO Pulmonary edema (marked) Conditions, if any, which gave rise to immediate cause (b) (c) Petechial spots, lungs, heart & thymus cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 2 days									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 10/16/56		22c. NAME OF CEMETERY OR CREMATORY Macadonia Cem.		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Esq., M.D.					ADDRESS		24a. REC'D BY REGISTRAR DATE Oct. 15, 1956		
24b. REGISTRAR'S SIGNATURE W. R. Hardy, M.D.					25. DEPUTY MEDICAL EXAMINER Oct. 14-1956				

TVVVVVVVVVVV

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death	
John Doe		45		Male		White		10-15-1956	
Place of Death		Cause of Death		Manner of Death		Occupation		Residence	
Hospital		Heart Disease		Natural		Teacher		123 Main St.	
Physician		Medical History		Social History		Family History		Autopsy	
Dr. Smith		Hypertension		Smoker		None		No	
Signature		Date		Time		Place		Initials	
[Signature]		10-15-1956		10:00 AM		Hospital		[Initials]	

BUREAU V. S.
 OCT 17 1956
RECEIVED

Within corporate limits

9902

CERTIFICATE OF DEATH

Reg. Dist. No. 4

DR. WHITWORTH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL—MEMORIAL AVE.				d. STREET ADDRESS 256 COLUMBIA ST.			
3. NAME OF DECEASED (Type or print) First ESTELLA M Middle NICKEL Last NICKEL				4. DATE OF DEATH Month OCT. Day 7 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23 1884		9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES DOWLAN				14. MOTHER'S MAIDEN NAME MOLLIE Batten			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Wreema - 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal Obst - (c) Carcinoma Rectum.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adeno Carcinoma Uterus 1953 -							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 , 19____, to Oct 7 , 19 56 that I last saw the deceased alive on 7 Oct , 19 56 , and that death occurred at 5:10 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Fuller B. Whitworth M.D.				ADDRESS (Street, city or town, state) 123 Bedford St - Fort			
DATE SIGNED Oct 7							
PHYSICIAN'S NAME (Type) Fuller B. Whitworth							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-10-1956		22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.				24a. REG'D BY REGISTRAR DATE Oct 9, 1956		24b. REGISTRAR'S SIGNATURE N. R. Mantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director must file it with the health department. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Y452J

DEPT. OF HEALTH - HOSPITAL - 1920

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CONFIDENTIAL

Y-23-1A

BUREAU V. S.

OCT 11 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files. No burial/cremation, or removal.

VS. A15ME(5)
SM 9/55

9909 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Barton, Rt. #1				c. LENGTH OF STAY IN 1b 10 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Laurel Run				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Patrick Middle Frances Last O'Halloran				4. DATE OF DEATH Month Oct. Day 4 Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> (WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Aug. 20-1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired machinest hepper-Celanese Corp.				10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, Md.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME James O' Halloran				14. MOTHER'S MAIDEN NAME Cecelia Bevens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 213-09-6439			
17. INFORMANT (daughter) Marie Shaw, Moscow, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis (angina syndrome) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH sudden about one year.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 4-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/56		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE 10-9-56	
				24b. REGISTRAR'S SIGNATURE Jannette M. Boal			

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

OCT 15 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

9910

Reg. Dist. No. 6

09867

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>McCool</u>	LENGTH OF STAY (in this place) <u>20 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>McCool</u>	STREET ADDRESS (If rural give location) <u>N. Main</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>N. Main</u>		STREET ADDRESS <u>N. Main</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary Virginia Patchett</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 1, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 24, 1893</u>
9. AGE last birthday <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Petersburg, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>W. Va.</u>	
13. FATHER'S NAME <u>Walter E. Ervin</u>		14. MOTHER'S MAIDEN NAME <u>Estelle Welton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT & ADDRESS <u>Joseph E. Patchett</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
334X IMMEDIATE CAUSE (A) <u>Hemiplegia right 3rd attack</u>		<u>19-54</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arterio-sclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arthritis deformans</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1954</u> , to <u>Oct 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-1-56</u> 19 <u>56</u> , and that death occurred at <u>10:35 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. H. Griffin</u>		DATE SIGNED <u>10-2-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal & Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Wallkill Valey</u>	
DATE THEREOF <u>10/8/56</u>		LOCATION (City, town, or county) (State) <u>Montgomery, N.Y.</u>	
24. REC'D BY REGISTRAR <u>John C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Keyser, W. Va.</u>	
DATE <u>10-3-56</u>		ADDRESS <u>Keyser, W. Va.</u>	

CERTIFICATE OF DEATH

3810

IN DEATH REGISTERED UNDER NO. 100000

PLACE OF DEATH

DATE

TIME

CAUSE

PLACE

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE

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BUREAU V. 1

OCT 8 1956

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FOR THE STATE

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STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
DIVISION OF STATISTICS
WASHINGTON, D. C.
OCT 8 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 189868											
9871 CERTIFICATE OF DEATH											
Reg. Dist. No. 4											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 5/2/56		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary					d. STREET ADDRESS 102 Wood Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anne			First Middle Last F. Porter		4. DATE OF DEATH October 6, 1956		Month Day Year				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/26/1876		9. AGE (In years last birthday) 80 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Secretary Western Union					10b. KIND OF BUSINESS OR INDUSTRY Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
11. BIRTHPLACE (State or foreign country)											
13. FATHER'S NAME Thomas G. Porter					14. MOTHER'S MAIDEN NAME Mary O'Conner						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO.						
17. INFORMANT P.O.Box 599, Allegany County Infirmary Records					Address Cumberland, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (d), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic myocardial degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral arteriosclerosis (c) Secondary anemia										INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic nephritis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 5/2/56, 19, to 10/6/56, 19, that I last saw the deceased alive on 10/6/56, 19, and that death occurred at 12:50 P.M., from the causes and on the date stated above.											
ACTUAL SIGNATURE Dr. James E. McLean					ADDRESS (Street, city or town, state) 49 Greene St., Md.			DATE SIGNED 10/8/56			
PHYSICIAN'S NAME (Type) Dr. James E. McLean					Cumberland, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 10-10-56		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Montesant					ADDRESS Hafer Funeral Home Frostburg, Md.		24a. REC'D BY REGISTRAR DATE Oct. 9, 1956		24b. REGISTRAR'S SIGNATURE W. R. Mantz M.D.		

CERTIFICATE OF DEATH

1956

Allegany County

Allegany County

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OCT 11-1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL REGISTATOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. R.J. WMS. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09869												
Within corporate limits 9872										CERTIFICATE OF DEATH												
Reg. Dist. No. 4																						
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 5 DAYS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND												
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL					d. STREET ADDRESS 817 MANN'S TERRACE					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) ROBERT First Middle Last RITTER					4. DATE OF DEATH Month OCTOBER Day 16 Year 19 56																	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 21 1904			9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman RE CO.					10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.			11. BIRTHPLACE (State or foreign country) MARYLAND, Lonaconing					12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME ALFRED RITTER					14. MOTHER'S MAIDEN NAME EFFIE GOODWIN																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 214-05-9893			17. INFORMANT MEMORIAL HOSPITAL					Address AVENUES MEMORIAL & WARWICK									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Cerebral Accident DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 days 2 yrs												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hemiparesis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from 10/17/54, 19 to 10/16/54, 19 that I last saw the deceased alive on 10/15/54, 19 and that death occurred at 8:55 A.M. from the causes and on the date stated above.																						
ACTUAL SIGNATURE [Signature] M.D.										ADDRESS (Street, City or town, state) Cumberland, Maryland					DATE SIGNED 10/16/56							
PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS																						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 10/18/56			22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul's			22d. LOCATION (City, town, or county) (State) Cumberland, Maryland											
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George										ADDRESS Cumberland, Md.					24a. RECEIVED BY REGISTRAR DATE Oct. 18, 1956			24b. REGISTRAR'S SIGNATURE [Signature]				

CERTIFICATE OF DEATH

6279

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OCT 23 1956

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CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>65 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>629 N. Centre Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>A</u> Last <u>Shroyer</u>				4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 2, 1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bottle inspector</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Brewing Company</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
13. FATHER'S NAME <u>John W. Shroyer</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Kornhoff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 05 4784</u>		17. INFORMANT Address <u>Eva. M. Shroyer, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>A few minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. <u> </u> p. <u> </u> m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Oct 24</u> , 19 <u>56</u> to <u>Oct 30</u> , 19 <u>56</u> , that I lost saw the deceased alive on <u>Oct 29</u> , 19 <u>56</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. M. Schindler</u>				ADDRESS (Street, city or town, state) <u>41 Green St, Cumberland, Md.</u>			
PHYSICIAN'S NAME (Type) <u>B. M. Schindler, M.D.</u>				DATE SIGNED <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-31-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. R. Kight</u>				ADDRESS <u>Cumberland, Md</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>				DATE <u>10-31-1956</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09871

9911

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oldtown</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oldtown</u> <u>md</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Geneva</u> Middle <u>Shryock</u> Last <u>Shryock</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29, 1869</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Picardy Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Athey</u>			14. MOTHER'S MAIDEN NAME <u>Mary E. Matthews</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Mary Elderton</u> Address <u>Oldtown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra cranial hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General atherosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>no yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-5</u> 19 <u>56</u> to <u>10-21-56</u> , that I last saw the deceased alive on <u>10-20-56</u> , and that death occurred at <u>Home</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>10-22-56</u>							
ACTUAL SIGNATURE <u>J. S. Armstrong</u> M.D.				DATE SIGNED <u>10-22-56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shryock Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Town Creek, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hager</u>				ADDRESS <u>Cumberland Md.</u>		24c. REC'D BY REGISTRAR DATE <u>Oct. 22, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Fay Duckworth</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9-11

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MEDICAL HISTORY [Faint text]		10. SIGNATURE OF PHYSICIAN [Faint text]	
11. SIGNATURE OF REGISTRAR [Faint text]		12. DATE OF DEATH [Faint text]	
13. PLACE OF DEATH [Faint text]		14. SIGNATURE OF DECEASED [Faint text]	
15. SIGNATURE OF WITNESSES [Faint text]		16. SIGNATURE OF FUNERAL HOME [Faint text]	
17. SIGNATURE OF BURIAL PLACE [Faint text]		18. SIGNATURE OF VENDOR [Faint text]	
19. SIGNATURE OF OTHER [Faint text]		20. SIGNATURE OF OTHER [Faint text]	
21. SIGNATURE OF OTHER [Faint text]		22. SIGNATURE OF OTHER [Faint text]	
23. SIGNATURE OF OTHER [Faint text]		24. SIGNATURE OF OTHER [Faint text]	
25. SIGNATURE OF OTHER [Faint text]		26. SIGNATURE OF OTHER [Faint text]	
27. SIGNATURE OF OTHER [Faint text]		28. SIGNATURE OF OTHER [Faint text]	
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89. SIGNATURE OF OTHER [Faint text]		90. SIGNATURE OF OTHER [Faint text]	
91. SIGNATURE OF OTHER [Faint text]		92. SIGNATURE OF OTHER [Faint text]	
93. SIGNATURE OF OTHER [Faint text]		94. SIGNATURE OF OTHER [Faint text]	
95. SIGNATURE OF OTHER [Faint text]		96. SIGNATURE OF OTHER [Faint text]	
97. SIGNATURE OF OTHER [Faint text]		98. SIGNATURE OF OTHER [Faint text]	
99. SIGNATURE OF OTHER [Faint text]		100. SIGNATURE OF OTHER [Faint text]	

BUREAU V. S.

OCT 24 1956

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>45yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>28 Virginia Ave.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>28 Virginia Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Wilson</u> Middle <u>M.</u> Last <u>Shumaker</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2, 1878</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Fairhope, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Solomon Shumaker</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Chrisner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-09-6121</u>		17. INFORMANT Address <u>William W. Shumaker, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced Age</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>Years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 56</u> , 19 <u> </u> , to <u>Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>56</u> , and that death occurred at <u>8:30</u> p. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. O. Himmelwright, M.D.</u>				G. OVERTON HIMMELWRIGHT, M. D. DATE SIGNED <u>10/31/56</u>			
PHYSICIAN'S NAME (Type) <u>G. O. Himmelwright, M.D.</u>				133 VIRGINIA AVENUE PH. PA 2-6212 CUMBERLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>W.R. Frank, M.D.</u>	
24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>				DATE <u>11/1/56</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

NOV 2 1956

RECEIVED

DR. R. J. WMS.

9875

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD c. LENGTH OF STAY IN 1b 33 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, d. STREET ADDRESS 39 MARY STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H Last SISK		4. DATE OF DEATH Month OCTOBER Day 12 Year 1956		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1908 SEPTEMBER 29		9. AGE (In years lost birth) 48 yrs.		10. IF UNDER 1 YEAR Months 4 Days 10 Hours 15 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboratory Tec.				10b. KIND OF BUSINESS OR INDUSTRY Textile Plant				11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland				12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME JAMES SISK						14. MOTHER'S MAIDEN NAME CARRIE TUCKER													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-07-4638				17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD. Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 yrs.																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____															
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 9/9/56 , 19____, to 10/12/56 , 19____, that I last saw the deceased alive on 10/12/56 , 19____, and that death occurred at 7:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 10/15/56 ACTUAL SIGNATURE _____ M.D. _____ PHYSICIAN'S NAME (Type) Richard J. Williams																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-15-56				22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.				22d. LOCATION (City, town, or county) (State) Cumberland, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli								ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE Oct 15, 1956				24b. REGISTRAR'S SIGNATURE W. R. M. M. D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2275

DATE OF DEATH

1956

1956

1956

1956

1956

1956

1956

BUREAU V. S.

OCT 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09874

Reg. Dist. No.

9876

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) ✓ a. STATE W.Va. b. COUNTY Mineral		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burlington 85x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Sade Sloan			4. DATE OF DEATH Month Day Year Oct. 26 19 56		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12-1879	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own house work		11. BIRTHPLACE (State or foreign country) W.Va.	
13. FATHER'S NAME John Sloan			14. MOTHER'S MAIDEN NAME E mma Stimmel		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Memorial Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure due to shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease with (c) mitral stenosis cause lost. 903.5					INTERVAL BETWEEN ONSET AND DEATH 23 days - several yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured right femur at the surgical neck.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) & fell to road. - Walking on hard surface road near home, lost her balance			
20c. TIME OF INJURY Month, Day, Year 6 P.m. Oct. 3 19 56	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Burlington, Mineral W.Va	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 26-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 28-1956	22c. NAME OF CEMETERY OR CREMATORY Sloan Family Cemetery near Burlington,		22d. LOCATION (City, town, or county) (State) W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Markwood Funeral Home, Keyser, W.Va.			24a. REC'D BY REGISTRAR Oct. 27, 1956 W.R. Frank M.D.		

Within corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. File pages 1 and 2 with the Registrar for burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, who shall be responsible for its use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09875

Within corporate limits 9877

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>76 Years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		d. STREET ADDRESS <u>209. Fulton Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>209. Fulton Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Smedley</u> Last <u>Smedley</u>		4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph M. Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Minna Damm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Nell Hughes, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. r. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 23, 1956</u> to <u>Oct 17, 1956</u> , that I last saw the deceased alive on <u>Oct 12, 1956</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>R. W. Trevas, Jr.</u> M.D. <u>Cumberland, Maryland</u>		<u>10/18/56</u>	
PHYSICIAN'S NAME (Type) <u>R. W. TREVAS JR, DR</u>		<u>Cumberland, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 20 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Knight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE Oct 19, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Mantz, M.D.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

RECEIVED
OCT 22 1956
BUREAU V. 3

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09876

DR. VAN ORMER . 9878

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 HRS. 5 MINS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL AVE.		d. STREET ADDRESS DAVIS	
3. NAME OF DECEASED (Type or print) First BESSIE Middle S Last SMITH		4. DATE OF DEATH Month OCTOBER Day 6 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 5, 1902
9. AGE (In years lost by day) 54 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME PINKNEY J. BLIZZARD	
14. MOTHER'S MAIDEN NAME SITES, PHOEBE J.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5410 Intestinal Hemorrhage, recurrent DUE TO (b) Innodent ulcer, Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Vascular disease			INTERVAL BETWEEN ONSET AND DEATH 3 week 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 1956 to 6 Oct 1956 that I last saw the deceased alive on 6 Oct 1956 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. A. Van Ormer		ADDRESS (Street, city or town, state) Cumberland, Md DATE SIGNED 8 Oct 56	
PHYSICIAN'S NAME (Type) W. A. VAN ORMER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-9-56	22c. NAME OF CEMETERY OR CREMATORY Davis Cemetery	22d. LOCATION (City, town, or county) (State) Davis, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE H. L. Hinkle		ADDRESS Davis, W. Va.	
24a. REC'D BY REGISTRAR Oct 9, 1956		24b. REGISTRAR'S SIGNATURE W. R. Thayer, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, pages 1 and 2, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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BUREAU V. 8

OCT 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. RANSOM

Within 9879 te limits

CERTIFICATE OF DEATH

Reg. Dist. No.

098774

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MOOREFIELD W. VA. COUNTY MOOREFIELD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 85 x 3			
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last SOUTHERLY				4. DATE OF DEATH Month 10 Day 9 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-7-56		9. AGE (In years last birthday) yrs. 2 IF UNDER 1 YEAR Months 2 Days 2 IF UNDER 24 HRS. Hours 2 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HAROLD C. SOUTHERLY				14. MOTHER'S MAIDEN NAME ELIZABETH WHETZEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity of VITAL Structures 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 776X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 776X				INTERVAL BETWEEN ONSET AND DEATH 2 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:50A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Ransom M.D.				ADDRESS (Street, city or town, state) 63 Greene St, Cumberland Md.			
PHYSICIAN'S NAME (Type) DR. L. RANSOM				DATE Oct 11 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10-10-56		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital,				ADDRESS Cumberland, Md.		24a. RECEIVED BY REGISTRAR Oct 11 1956	
						24b. REGISTRAR'S SIGNATURE M. R. Drantz, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2060201XV0

RECEIVED

10:5

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09878

DR. REITER

9880

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle BARRY Last STEGMAIER		4. DATE OF DEATH Month OCTOBER Day 25 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 13, 1956
9. AGE (In years lost birthday) yrs. 12 Months 12 Days 12 Hours 12 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN T. STEGMAIER		14. MOTHER'S MAIDEN NAME IRIS BORROR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 756.2 Intestinal obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 12 days DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 20, 1956 , to Oct 25, 1956 , that I last saw the deceased alive on Oct 25, 1956 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph A. Reiter		ADDRESS (Street, city or town, state) 112 Bedford St. Cumberland, Md. DATE SIGNED Oct 25, 1956	
PHYSICIAN'S NAME (Type) RALPH A. REITER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-56	
22c. NAME OF CEMETERY OR CREMATORY St. Mary Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Oct 27, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frank M.D.	

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL REGISTAR: After this certificate has been signed by the attending physician and completed in by the funeral director, the registrars should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

2062211XV6

BUREAU V. S.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Within corporate limits
9881
CERTIFICATE OF DEATH

09879

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>912 Glenwood St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ethel</u> Last <u>Steppe</u>				4. DATE OF DEATH Month <u>October</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/9-96</u>	9. AGE (In years lost birthday) yrs. <u>60</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Henry Nose</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Parnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Husband Albert John Steppe</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1954</u> to <u>Oct 18, 1956</u> that I last saw the deceased alive on <u>Oct 18, 1956</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE <u>B. M. Schindler</u>		M.D. <u>41 Green St., Cumberland Md.</u>		ADDRESS (Street, city or town, state)			
PHYSICIAN'S NAME (Type) <u>B. M. Schindler, M.D.</u>		<u>41 Green St., Cumberland Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Oct 22, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>M. R. Grant, M.D.</u>			

OCT 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9882

CERTIFICATE OF DEATH

Reg. Dist. No.

09880

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 62 CUMBERLAND				c. LENGTH OF STAY IN 1b 3 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle L. Last STEVENS				4. DATE OF DEATH Month OCTOBER Day 25 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 30, 1879	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min. 7		IF UNDER 24 HRS. Months 7 Days 7 Hours 7 Min. 7			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEHOLD DUTIES				10b. KIND OF BUSINESS OR INDUSTRY MEMORIAL HOSPITAL		11. BIRTHPLACE (State or foreign country) BERLIN, PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME THOMAS STEVENS				14. MOTHER'S MAIDEN NAME LAVINA BROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-10-8836		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General malnutrition and weakness 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Secondary to Carcinoma ascending Colon DUE TO (c) Colorectal							INTERVAL BETWEEN ONSET AND DEATH 1 yr 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10 Oct , 19 56 , to 25 Oct , 19 56 , that I last saw the deceased alive on Oct 25 , 19 56 , and that death occurred at 9:05 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Carlton Brinsfield				ADDRESS (Street, city or town, state) 232 Baltimore Ave			
PHYSICIAN'S NAME (Type) CUMBERLAND MD				DATE SIGNED Oct 27, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 27 1956		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. R. Frank				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Oct 27, 1956	
				24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.
OCT 30 1956

Reg. Dist. No.

VS. A15ME(5)
SM 9/55

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 18
THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, and cause of death. The text is mirrored and difficult to read.

BUREAU V. S.

OCT 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09882

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN lb 36 yrs.		d. STREET ADDRESS 568 Fayette St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 568 Fayette St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Arthur Owen Swann		4. DATE OF DEATH Oct. 26 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21-1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR 72 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-Warehouse man		10b. KIND OF BUSINESS OR INDUSTRY Kenneweg Co.	
11. BIRTHPLACE (State or foreign country) Bloomington, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Thomas Swann		14. MOTHER'S MAIDEN NAME Mary Fitzwalter Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-4775	
17. INFORMANT Mrs. J. B. Burke, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Oct. 27-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 30, 1956	22c. NAME OF CEMETERY OR CREMATORY Sts. Peter & Paul Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.		24a. REC'D BY REGISTRAR Oct. 29, 1956	
ADDRESS		24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. File pages 1 and 2 with the Registrar for burial, cremation, or removal.

RECEIVED

OCT 30 1956

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9904

CERTIFICATE OF DEATH

69883

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bealls Lane</u>		d. STREET ADDRESS <u>Bealls Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>(THOMAS)</u> Last <u>TAYLOR</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-28-1877</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Martha Davies</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Ralph Race, Frostburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>X</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>54</u> , to <u>10/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/5/56</u> , 19 <u>56</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Martin M. Rothstein</u> M.D.		48 Broadway - Frostburg, Md. 10/6/56	
PHYSICIAN'S NAME (Type) <u>MARTIN M. ROTHSTEIN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-7-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>F.B.G. Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst,</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>10-7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Dur Nancy H. Lee</u>	

CERTIFICATE OF DEATH

DECEASED NAME JOHN R. ROBERTS		SEX MALE		AGE 68	
DATE OF DEATH OCT 8 1956		PLACE OF DEATH HOME		COUNTY BALTIMORE	
TIME OF DEATH 10:15 AM		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
PLACE OF BIRTH BALTIMORE, MD		DATE OF BIRTH OCT 15 1888		SEX AT BIRTH MALE	
OCCUPATION RETIRED		MARITAL STATUS MARRIED		EDUCATION HIGH SCHOOL	
PREVIOUS ILLNESS HYPERTENSION		MEDICAL HISTORY NO		SURGICAL HISTORY NO	
PHYSICIAN DR. J. H. ROBERTS		HOSPITAL NO		CORONER NO	
SIGNATURE OF PHYSICIAN J. H. ROBERTS		SIGNATURE OF CORONER J. H. ROBERTS		SIGNATURE OF DECEASED J. H. ROBERTS	

BUREAU N. 11

OCT 9 1956

RECEIVED

9884

CERTIFICATE OF DEATH

Reg. Dist. No.

9884

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 Boone Street, Cumberland, Md. 02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 30 Boone Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Teal Last Teal		4. DATE OF DEATH Month October Day 31 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/21/1865
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York, New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Peter Wagner		14. MOTHER'S MAIDEN NAME Elizabeth Neis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.1 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Cerebral arteriosclerosis (c) Senile Deterioration	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 6th, 1956 to Oct. 31st, 1956 , that I last saw the deceased alive on Oct. 30th, 1956 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED Oct. 31st	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		49 Greene St., Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/56	
22c. NAME OF CEMETERY OR CREMATORY Hill Crest		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Oct. 1, 1956 24b. REGISTRAR'S SIGNATURE W. F. Brady, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be filed with the registrar. The registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

Name of Deceased James P. Scorsone		Date of Death 10/21/55	
Place of Birth New York, New York		Date of Birth 10/21/1885	
Usual Residence 30 Boone Street, Cumberland, Md.		Cause of Death (To be filled in by physician)	
Signature of Physician (To be filled in by physician)		Signature of Registrar (To be filled in by registrar)	
Date of Report 10/21/55		Place of Death (To be filled in by registrar)	
Name of Informant (To be filled in by informant)		Address of Informant (To be filled in by informant)	
Signature of Informant (To be filled in by informant)		Date of Report 10/21/55	

BUREAU V. 2

NOV 2 1955

RECEIVED

James P. Scorsone
 Cumberland, Md.
 10/21/55
 10/21/55

09885

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 16 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Scott Middle H. Last Tewell		4. DATE OF DEATH Month Oct. Day 22 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22-1884
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ed-Merchant	
11. BIRTHPLACE (State or foreign country) Chaneysville, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Johnson Dorwin Tewell		14. MOTHER'S MAIDEN NAME Evaline Northcraft	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Sacred Heart Hospital records.	
17. INFORMANT Sacred Heart Hospital records.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO Pulmonary edema (marked) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) about 9 hrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Oct. 22-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 25, 1956	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR Oct. 26, 1956	
24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to a burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
Johnston, John H.		30		Male		White	
Place of Birth		Date of Birth		Date of Death		Time of Death	
Towson, Maryland		Nov. 22, 1925		Nov. 22, 1925		10:30 P.M.	
Cause of Death		Manner of Death		Occupation		Education	
Coronary atherosclerosis		Natural		Carpenter		High School	
Medical History		Family History		Social History		Habitual Habits	
Hypertension		None		None		None	
Previous Illnesses		Previous Operations		Previous Injuries		Previous Accidents	
None		None		None		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
OCT 29 1956
BUREAU V. S.

9886

09886

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 632 N. Centre St.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HERBERT Middle NELSON Last THOMPSON				4. DATE OF DEATH Month Oct. Day 7, Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1914		9. AGE (In years last birthday) 42 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Mathias Thompson				14. MOTHER'S MAIDEN NAME Pearl Twigg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,				16. SOCIAL SECURITY NO. 214-05-7022			
17. INFORMANT Mrs. Wm. C. Weisenmiller				Address Cumberland, Md. 632 N. Centre St.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) congestive heart failure 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cor pulmonale DUE TO (c) emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 days 1 year 2 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-3 , 19 56 , to 10-7 , 19 56 , that I last saw the deceased alive on 10-6 , 19 56 , and that death occurred at 3:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Green St. Cumberland Md. DATE SIGNED							
ACTUAL SIGNATURE Lewis Brings M.D.							
PHYSICIAN'S NAME (Type) LEWIS BRINGS Cumberland Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/56		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.			
24a. REC'D BY REGISTRAR 10/9/56				24b. REGISTRAR'S SIGNATURE W. R. Dratz, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 1948
 CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1903		BALTIMORE		MD		USA			
OCCUPATION		EDUCATION		MARRIAGE		MOTHER		FATHER		MOTHER		FATHER			
Carpenter		High School		Married		Mary H. Harris		John H. Harris		Mary H. Harris		John H. Harris			
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		MAYOR		CLERK			
JAN 15 1948		BALTIMORE		HEART DISEASE		NATURAL		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS			

BUREAU V. S.

OCT 11 1956

RECEIVED

9887

09887

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland MD</u>	
c. LENGTH OF STAY IN 1b <u>65 life</u>		d. STREET ADDRESS <u>20 N. Chase Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>20 N. Chase Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Robb</u> Last <u>Tyler</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 14 1882</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Engineer Corps</u>	
11. BIRTHPLACE (State or foreign country) <u>Richmond Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>M. Brooke Tyler</u>		14. MOTHER'S MAIDEN NAME <u>Helen Hobson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-07-4168</u>	
17. INFORMANT <u>Randolph Tyler</u> Address <u>Cumberland MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Senez Carcinoma</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>1-10</u> , 19 <u>56</u> , to <u>10-7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-7</u> , 19 <u>56</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph W. Ballin</u> M.D.		ADDRESS (Street, city or town, state) <u>62 Greene St Cumberland Md</u> DATE SIGNED <u>10-8-56</u>	
PHYSICIAN'S NAME (Type) <u>RALPH W. BALLIN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 9 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>	22d. LOCATION (City, town, or county) <u>Frostburg MD</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumberland MD</u>		24a. REC'D BY REGISTRAR <u>DATE Oct. 9, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>W. R. Mantz, M.D.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
MARRIED		JULY 1, 1968		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		ATTORNEY	
EDUCATION		SCHOOLING		RELIGION		HABIT		TOLERANCE		PREVIOUS ILLNESS	
HIGH SCHOOL		12		METHODIST		SMOKING		NONE		NONE	
MILITARY SERVICE		REMARKS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES		DATE	
NONE		DECEASED WAS FOUND BY POLICE AT HIS HOME IN MEMPHIS, TENNESSEE, ON JULY 1, 1968. HE WAS FOUND WITH A SUICIDE NOTE.		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JULY 1, 1968	

NOTICE: This certificate is subject to the provisions of the Maryland Health and Safety Code, Title 18, Subtitle 1, Chapter 10.

BUREAU V. S.

JUL 11 1968

RECEIVED

Within corporate limits

9888

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 33 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS RT. #3, VALLEY ROAD			
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ROBERT W. WEAVER				4. DATE OF DEATH OCTOBER 8 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 18, 1899	
9. AGE (In years by birthday) 58 yts.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10b. KIND OF BUSINESS OR INDUSTRY Used Car Parts		11. BIRTHPLACE (State or foreign country) Garrett, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY WEAVER				14. MOTHER'S MAIDEN NAME HATTIE WALTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-10-6790		17. INFORMANT Mrs. Evelyn Flowers Weaver Cumberland, Mary.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 mos 3 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-12 1954 to 10-8 1956 , that I last saw the deceased alive on 10-8 1956 , and that death occurred at 2:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph W. Ballin				ADDRESS (Street, city or town, state) 62 Greene St. Cumberland, Md			
DATE SIGNED 10-9-56							
PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/56		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hofer				ADDRESS Cumberland, Md		24a. REC'D BY REGISTRAR W. R. Hantz	
				DATE Oct 11, 1956		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be filed with the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 must be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 15 1956

RECEIVED

1
Within corporate limits **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**
9889 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09889

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) City Jail		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Harry Middle William Last West		4. DATE OF DEATH Month Oct. Day 3 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12-1928
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months 27 Days 27 Hours 27 Min.	IF UNDER 24 HRS. Months 27 Days 27 Hours 27 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen mechanic		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Keyser, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13. FATHER'S NAME Charles Carter		14. MOTHER'S MAIDEN NAME Margaret West	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes-after W.W.2		16. SOCIAL SECURITY NO. 220-16-6301	
17. INFORMANT (mother) Margaret Vandergrift, Cumberland		Address Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (b) Strangulation (c) Strangulation DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION GIVEN IN PART I (a) He had been confined in the Springfield State Hospital		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Hung himself by his shirt in City Jail cell.		20c. TIME OF INJURY Month, Day, Year 1 - 10 - 1956	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) City Jail	
20f. (City or town) Cumberland, Allegany, Md.		(County) (State)	

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 3-1956	

22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 10-5-1956	
22c. NAME OF CEMETERY OR CREMATORY Allegany County Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Light, Cumberland, Md.		24a. REC'D BY REGISTRAR Oct. 5, 1956	
		24b. REGISTRAR'S SIGNATURE W. R. Martz, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. The Registrar may file pages 1 and 2 with the Registrar's Office for burial, cremation, or removal.

RECEIVED
OCT 8 1956
BUREAU V. S.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - EASTING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Name: [illegible]
Age: [illegible]
Sex: [illegible]
Race: [illegible]
Date of Birth: [illegible]
Date of Death: [illegible]
Place of Birth: [illegible]
Cause of Death: [illegible]
Manner of Death: [illegible]
Signature: [illegible]
Date: [illegible]

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9912

CERTIFICATE OF DEATH

09890

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 1, Cumberland</u>				c. LENGTH OF STAY IN 1b <u>55yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 1, Cumberland, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Anthony Wheeler</u>				4. DATE OF DEATH Month Day Year <u>Oct. 24 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 18, 1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Projectionist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Theatre Business</u>		11. BIRTHPLACE (State or foreign country) <u>Piedmont, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Edward L. Wheeler</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Louise Rowan</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>War I</u>			
16. SOCIAL SECURITY NO. <u>213-10-7160</u>				17. INFORMANT Address <u>Mrs. Joseph A. Wheeler, Cumberland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, lung, far advanced</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Approx 2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>20 Oct</u> , 19 <u>56</u> , to <u>24 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>24 Oct</u> , 19 <u>56</u> , and that death occurred at <u>1:50 A. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Carlton Brinsfield</u>				M.D. <u>232 Baltimore Ave Cumberland, Md.</u>			
PHYSICIAN'S NAME (Type) <u>CARLTON BRINSFIELD M.D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-27-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY		HISTORY OF PRESENT ILLNESS		HISTORY OF PREVIOUS ILLNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 2

OCT 30 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. The funeral director should be given a copy of this certificate and a copy of the death certificate. The funeral director should be given a copy of this certificate and a copy of the death certificate. The funeral director should be given a copy of this certificate and a copy of the death certificate.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09891

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) -Flintstone		c. LENGTH OF STAY IN 1b 60 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Russell Clay Wilson		4. DATE OF DEATH Oct. 6 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7-1883
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: Months 6 Days 19 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Odd jobs.	
11. BIRTHPLACE (State or foreign country) Hyndman, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Wilson		14. MOTHER'S MAIDEN NAME Elizabeth Robinette	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-0404	
17. INFORMANT (brother) Ralph Wilson, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden ?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 6-1956		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-56	
22c. NAME OF CEMETERY OR CREMATORY Oddfellows Cemetery		22d. LOCATION (City, town, or county) (State) Flintstone, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland, Md.	
24a. RECEIVED BY REGISTRAR Oct. 8, 1956		24b. REGISTRAR'S SIGNATURE M. R. Crantz, M.D.	

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
James L. Wilson		60 yrs		Male		White		10-1-56		Home	
Residence		Occupation		Cause of Death		Manner of Death		Time of Death		Signature of Examiner	
1234 Main St., Birmingham, Ala.		Retired		Heart Disease		Natural		10:00 AM		J. L. Smith	
Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker	
J. L. Smith		J. L. Smith		J. L. Smith		J. L. Smith		J. L. Smith		J. L. Smith	

BUREAU V. 8

OCT 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, pages 1 and 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09892

Within corporate limits 9890

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10/16/54	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS Route #1, Box 489	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Terrance Middle T. Last Woods		4. DATE OF DEATH Month October Day 11 , Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/30/1870
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Coal Mining		10b. KIND OF BUSINESS OR INDUSTRY South Shields, England	
11. BIRTHPLACE (State or foreign country) County Dorn		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bernard Woods		14. MOTHER'S MAIDEN NAME Dorothy Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 36 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic hepatitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/16/54 , 19____, to 10/11/56 , 19____, that I last saw the deceased alive on 10/11/56 , 19____, and that death occurred at 10:40 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 10/11/56			
ACTUAL SIGNATURE James E. McLean M.D.			
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/13/56	22c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery	22d. LOCATION (City, town, or county) (State) Lonaconing, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing Md.	
24a. RECORD BY REGISTRAR DATE Oct. 12/1956		24b. REGISTRAR'S SIGNATURE W. R. Trantz, M.D.	

CERTIFICATE OF DEATH

RECEIVED
 OCT 15 1956
 BUREAU V. S.

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Birth		Place of Death	
John Doe		45		Male		White		1911		1956		New York		New York	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Social Security Number		Last Known Address		Last Known Telephone	
Heart Disease		Natural		Teacher		High School		Married		123-45-6789		123 Main St		123-45-6789	
Physician's Signature		Physician's Name		Physician's Address		Physician's Telephone		Physician's License Number		Physician's State		Physician's Country		Physician's City	
[Signature]		Dr. John Smith		123 Main St		123-45-6789		12345		New York		New York		New York	
Coroner's Signature		Coroner's Name		Coroner's Address		Coroner's Telephone		Coroner's License Number		Coroner's State		Coroner's Country		Coroner's City	
[Signature]		Mr. John Doe		123 Main St		123-45-6789		12345		New York		New York		New York	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's Telephone		Medical Examiner's License Number		Medical Examiner's State		Medical Examiner's Country		Medical Examiner's City	
[Signature]		Dr. John Smith		123 Main St		123-45-6789		12345		New York		New York		New York	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09893

DR. VAN ORMER

9891

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b I DAY	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 1205 HOLLAND ST	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAGNUS MAXWELL		4. DATE OF DEATH OCTOBER 2, 1956	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 20, 1904	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Safety Engineer - Art. Silk Mill		10b. KIND OF BUSINESS OR INDUSTRY SCOTLAND	
11. BIRTHPLACE (State or foreign country) SCOTLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES P. WORK		14. MOTHER'S MAIDEN NAME JESSIE RONTOL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 168-01-3252	
17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis, acute (b) arteriosclerotic Heart Disease (c) Hypertensive Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1951, 19 to 2 Oct., 1956, that I last saw the deceased alive on 2 Oct., 1956, and that death occurred at 8:05 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 122 S. Center St. DATE SIGNED 2 Oct. 56	
ACTUAL SIGNATURE W. A. Van Ormer		M.D. Cumberlnd, Md.	
PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/56	
22c. NAME OF CEMETERY OR CREMATORY Homewood Cemetery		22d. LOCATION (City, town, or county) (State) Pittsburgh, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox- Cumberland, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE Oct. 4, 1956		24b. REGISTRAR'S SIGNATURE W. R. Mantz, M.D.	

CERTIFICATE OF DEATH

1956

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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CAUSE OF DEATH

DECEASED - Mrs. Silk Hill

DATE OF BIRTH

PLACE OF BIRTH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

OCT 8 1956

RECEIVED

Homeood Cemetery

10/8/56

H. Lee Slick - Cumberland, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9892

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09894

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN lb <u>35 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>119 W. First St.</u>				d. STREET ADDRESS <u>119 W. First St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Luther</u> Last <u>Wotring</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>29</u> Year <u>19 56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14-1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B&O.R. Ry.</u>		11. BIRTHPLACE (State or foreign country) <u>Preston Co. W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William F. Wotring</u>				14. MOTHER'S MAIDEN NAME <u>Eva E. Nines</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>(wife) Jennie Love Wotring, Cumberland, Md</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> about <u>7 hrs.</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u>(Angina syndrome)</u> about <u>1 week</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct. 29-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 31, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>October 30, 1956</u>			
				24b. REGISTRAR'S SIGNATURE <u>W. L. Frank, M.D.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file as a burial-cremation permit. File pages 1 and 2 with the registrar for a burial-cremation permit or removal.

BUREAU V. S.

NOV 1 1956

RECEIVED
NOV 1 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file. If the body is to be removed, the FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9914 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Allegany</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kifer</i>			c. LENGTH OF STAY IN 1b <i>15 years</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>In woods near home</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Floyd Raymond Youngblood</i>			4. DATE OF DEATH <i>Oct 19 1956</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug-28-1897</i>		
9. AGE (In years last birthday) <i>59</i> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Building</i>		
11. BIRTHPLACE (State or foreign country) <i>Pow Pow W. Va</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>William Youngblood</i>			14. MOTHER'S MAIDEN NAME <i>Anna Mae Donald</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>232-10-2534</i>		
17. INFORMANT <i>Mrs. Bertha Youngblood</i>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial failure</i> DUE TO (b) <i>Chronic myocarditis</i> DUE TO (c) <i>Arteriosclerosis with hypertension</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>several</i> <i>years</i> <i>several</i> <i>years</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>H. V. Derriving M.D.</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>H. V. Derriving M.D.</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			22b. DATE THEREOF <i>Oct. 22-1956</i>		
22c. NAME OF CEMETERY OR CREMATORY <i>Camp Hill Cemetery</i>			22d. LOCATION (City, town, or county) (State) <i>Pow Pow W. Va</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. D. Parks</i>			24a. REC'D BY REGISTRAR <i>Oct. 21, 1956</i>		
ADDRESS <i>Berkeley Springs, W. Va</i>			24b. REGISTRAR'S SIGNATURE <i>Mrs. Fay Buckworth</i>		

MEDICAL CERTIFICATION

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

BUREAU V. 3

OCT 24 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09896

Within corporate limits

9893

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allerany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland, Md.</u>		<u>60yrs</u>		TOWN <u>Cumberland, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>807 Shriver Ave.</u>				STREET ADDRESS (If rural give location) <u>807 Shriver Ave</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>George Edward Zapf</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10-13-56</u> 19 <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 21, 1883</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist Railroad</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>George E. Zapf Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Barreis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-09-8569</u>		17. INFORMANT & ADDRESS <u>Agnes Zapf 807 Shriver Ave</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Chronic myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				<u>2 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 8, 1956</u> , to <u>Oct 13, 1956</u> , that I last saw the deceased alive on <u>Oct 13, 1956</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>R. W. Treaschke, Jr.</u>				ADDRESS (Street, city, town, state) <u>M.D. Cumberland Maryland</u>		DATE SIGNED <u>10/15/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-17-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Patrick Cem</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. RECEIVED BY REGISTRAR <u>Oct. 16, 1956</u>		REGISTRAR'S SIGNATURE <u>R. R. Treaschke, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>		ADDRESS <u>Cumberland, Md.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEAREST RELATIVE

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF STATE

22. SIGNATURE OF COUNTY

23. SIGNATURE OF TOWNSHIP

24. SIGNATURE OF VILLAGE

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BUREAU V. S.

OCT 18 1956

RECEIVED

SMOULDERING